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Snowy fields on Bald Knob at Canaan Valley, W.Va. in Tucker County. Photo courtesy of *Steven J. Shaluta Jr.,* West Virginia Division of Tourism and Parks.

An overview of Medical Savings Accounts

Editor's Note: *The following text is from a White Paper which the West Virginia State Medical Association is preparing to educate members and the public about medical savings accounts.*

Physician members of the West Virginia State Medical Association, are, like many citizens throughout this state and across the nation, concerned about the future of health care. Obviously, there are flaws in the system, but Americans still enjoy the benefits of the world's best medical care. To change the way such care is provided could destroy the quality of that care entirely.

Our challenge, then, is to correct those problems, specifically access and cost, without damaging the core component of our health care system - - choice. With that goal in mind, the WVSMA has endorsed the philosophy of Patient Power - - allowing individuals to make their own decisions about what they need and want in medical care.

The specific recommendations that Patient Power endorses are centered around the establishment of individual Medical Savings Accounts (MSAs). These accounts would allow individuals and families to determine how their health care dollars are spent. The accounts would be funded by an individual, an employer or both. A portion of the money could be used to buy a high deductible catastrophic insurance policy to cover the individual or family for any major need, with the remainder being available to pay for routine medical expenditures while satisfying the deductible. Any money remaining in the account at the end of each year could be rolled-over and allowed to accumulate with interest for future medical expenses. The funds set aside for the MSAs would be exempt from state taxes, and if a federal exemption is granted, free from federal taxes. Any interest accrued on these funds would have the same tax exemptions.

The premise behind MSAs is to allow individuals and their families to buy policies appropriate for their particular needs, instead of being forced to take a one-size fits all mandated policy. By doing so, access will increase because there will be more of an incentive for people to obtain medical insurance because the MSAs earn interest and are a stable source of income to pay for health care, especially for long-term care.

Another positive aspect behind MSAs is that these accounts allow the individual and his/her family the freedom of choice to decide who will provide their care. For example, if an individual with an MSA wants to participate in a managed health care plan, that is his/her decision. Additionally, the employer is not burdened with the unnecessary paperwork of dealing with certain providers or insurance companies.

Cost savings could also result for employers. Many employers who do not offer health insurance have a tremendous turnover rate. By making it more economical to jointly provide coverage with their employees, the employer's costs for training employees would go down because their turnover rate would decrease.

Additionally, with the establishment of Medical Savings Accounts, portability of insurance will be provided and pre-existing conditions should be eliminated.

To help you more fully understand Medical Savings Accounts, the following questions and answers have been provided by the Council For Affordable Health Insurance:

Q. Can the MSA be compatible with managed care arrangements, and what is the mechanism by which this can be done?

A. Yes. The MSA concept would work well with managed care. For example, individuals can take a portion of their MSA balance and purchase HMO or indemnity coverage if they wish. Furthermore, it is increasingly clear that managed care (such as individual case management) is not particularly effective when used for routine health services and works best for high cost conditions for which there are alternative treatment options. Insurers who include rigorous managed care tools in their catastrophic umbrella policy will gain price advantages over those who do not use these tools. Competition will encourage continued efforts to find the managed care techniques that reduce the costs of catastrophic care.

Q. Is it likely that most people will choose to remain with their traditional coverage because otherwise, they would be exposed to the risk of paying medical expenses in excess of the balances in their medical savings account?

A. No, most people will likely choose to move to an MSA arrangement for the following reasons:

1. The MSA is intended to be supplemented with a catastrophic insurance policy. People would thus be able to avoid the risk of paying medical expenses in excess of the balances in their MSAs.
2. For most employees, the possiblity of building up funds through an MSA with their employer's money will be far more attractive than the certainty that they will not be able to do so under their current policy.
3. Individuals will no longer have to forego treatment because they cannot afford co-payments or deductible requirements. In addition, costs will be lower initially due to lower administrative expenses, and over time would be less because of lower utilization.

Q. Would all individuals be required to buy insurance?

A. No. We do not favor compulsory insurance. However, with an attractive program like MSAs available, there will be more incentive for young, healthy people to participate. By not using all that's available each year

in their MSAs, people will see the savings grow every year and money would be accessible for their medical care.

Q. What would be done to assist lower-income families in meeting their medical expenses?

A. Refundable tax credits and/or medical care vouchers could be allowed for those individuals who would need some assistance in meeting their medical expenses.

Q. What changes, if any, would be made in the private insurance market to ensure that individuals and families could buy a health insurance policy from an insurance carrier?

A. Small group reform measures such as full portability for those with continuous coverage, renewability of coverage, and limits on rate increases, which would make coverage much more affordable.

Q. Where will the money come from for the tax credits/vouchers?

A. The WVSMA recommends passing legislation implementing a tobacco excise tax. Currently, state excise taxes are only imposed on cigarettes. The WVSMA supports taxing all tobacco products. According to the West Virginia Tobacco Control Coalition, by passing such legislation there would be an increase in revenue in 1995 from the $31 million from cigarettes only, to approximately $74 million from all tobacco products.

As these questions and answers illustrate, through Patient Power there is an alternative to improving our health care system without major changes to the current system -- which is recognized as the best in the world.

Health Access celebrates first year of service

In his speech at the celebration, AMA Trustee Dr. Michael Goldrich praised Health Access staff members, volunteers and community leaders for their roles in making the clinic such a success. Nancy Tonkin of the West Virginia Hospital Association (seated second from right) was the other guest speaker for this special occasion.

Dr. Doug McKinney proudly accepts his award for being named one of the Physicians of the Year for Health Access, Inc. Dr. McKinney and the other Physician of the Year Dr. Paul Davis, care for patients both at the clinic and at their offices and serve on its board of trustees.

Staff members and volunteers for Health Access, Inc., Clarksburg's free clinic, gathered with members of the community and a variety of special guests at the Rose Garden Theater on Sunday, November 7 to celebrate caring for 1,500 patients during the clinic's first year of operation.

"The efforts of the Harrison County Medical Society, the Harrison County Medical Society Auxiliary local business leaders and members of the community have made this first year for Health Access a phenomenal success," Aaron Taylor, the clinic's executive director said. "We have been able to expand our services dramatically since we opened last October because of the generosity and dedication of so many people from all over the state and from every aspects of the Clarksburg community. We are very proud to now have a full-time medical director, Dr. Suzanne Goodyear, on staff, as well as a full-time pharmacist, Marcy McIntire."

The annual meeting activities began with the premiere of a special film about Health Access which was created by WDTV in Clarksburg. Following this presentation, Senator Jay Rockefeller delivered a special filmed congratulations to Dr. Louis Ortenzio, the clinic's founder and chairman of the board, and everyone attending the ceremony who helped contribute to Health Access' success. The keynote addresses were then delivered by AMA Trustee Dr. Michael Goldrich and Nancy Tonkin of the West Virginia Hospital Association.

Numerous awards were given at the meeting to the clinics' volunteers who gave an incredible total of 10,427 hours of their time to the clinic before and during the first year of operation. Among those honored were Dr. Doug McKinney and Dr. Paul Davis as physicians of the year; and the Harrison County Medical Society Alliance members were named Organization of the Year.

Radiation therapy for stage III non-small cell lung cancer: a curative treatment option

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Abstract

This paper analyzes our treatment results for a selected group of Stage III non-small cell lung cancer (NSCLC) patients treated with irradiation alone. One, two and five-year survival rates were 42%, 20% and 6% respectively. Survival rates for patients with Stage IIIA and Stage IIIB disease were similar. Our results agree with the literature and confirm that 5% of selected patients with Stage III NSCLC will be disease free and potentially cured, five years after treatment with irradiation.

Recurrence in the radiation field continues to be a major problem for patients with Stage III NSCLC, accounting for the initial site of failure in 40%-55% of patients. Improvements in local control will likely improve survival rates somewhat; but, because of the marked propensity for these cancers to ultimately metastasize, significant improvement in survival rates will only occur when effective systemic therapy becomes available.

Introduction

Lung cancer (1) is a common and deadly malignancy. Based on histologic features and clinical behavior, it is divided into two groups: small-cell lung cancer and non-small cell lung cancer. Approximately 75% of lung cancers are of the non-small cell variety (squamous carcinoma, adenocarcinoma and large-cell carcinoma) and 25% are of the small-cell type.

Chemotherapy is the primary treatment for small-cell lung cancer.

Table 1. **Current Staging System for Lung Cancer**

Abridged AJCC (American Joint Committee on Cancer)

Primary Tumor

T_1 - Tumor ≤ 3 cm in size, not involving visceral pleura and located distal to mainstem bronchus

T_2 - Tumor with any of the following : a) > 3 cm in size b) involving visceral pleura c) atelectasis involving hilar region d) involving mainstem bronchus > 2 cm distal to carina

T_3 - Tumor of any size involving any of the following: chest wall, diaphragm, mediastinal pleura, pericardium or tumor in mainstem bronchus within 2 cm of carina or atelectasis of entire lung

T_4 - Tumor of any size invading any of the following: mediastinal structures, vertebral body, carina or a malignant pleural effusion

Regional Lymph Nodes

N_0 - No nodal metastasis

N_1 - Metastasis in ipsilateral peribronchial nodes or ipsilateral hilar lymph nodes

N_2 - Metastasis in ipsilateral mediastinal nodes or subcarinal lymph nodes

N_3 - Metastasis in contralateral mediastinal nodes, contralateral hilar nodes or supraclavicular lymph nodes

Metastatic Disease

M_1 - Presence of metastatic disease

Stage Grouping

Stage I	T_{1-2}	N_0	M_0
Stage II	T_{1-2}	N_1	M_0
Stage IIIA	T_{1-3}	N_2	M_0
	T_3	N_{0-2}	M_0
Stage IIIB	Any T	N_3	M_0
	T_4	Any N	M_0
Stage IV	Any T	Any N	M_1

Table 2. **Stage III Lung Cancer Patients**

Distribution by TN Classification and Stage Subgrouping.

IIIA		IIIB	
T_2N_2	8	T_4N_0	16
T_3N_0	13	T_4N_1	1
T_3N_1	1	T_4N_2	5
T_3N_2	6		
Total Patients:	28		22

Table 3. **Survival, Stage IIIA vs Stage IIIB**

Stage	% Surviving at:			
	12 Months		18 Months	
IIIA	50	(n=14)	36	(n=10)
	p=.196, NS*		p=.171, NS*	
IIIB	32	(n=7)	18	(n=4)

(n)=Number of Patients Alive, p=Values of Significance, *NS=Not Statistically Significant

For non-small cell lung cancer, surgery is the primary treatment for resectable disease, and radiation therapy is the primary treatment for unresectable cancer. The term lung cancer will refer to non-small cell lung cancer throughout the rest of this paper.

Approximately 125,000 cases of lung cancer were diagnosed in 1992 (2). The current staging system for lung cancer is shown in Table 1. At presentation, approximately 1/3 of patients have resectable cancer (Stage I & II); 1/3 have metastatic disease (Stage IV); and 1/3 have locally advanced but non-metastatic disease (Stage III). For each stage, the best survival is seen in patients with a performance status ranging from good to excellent and with minimal or no weight loss (1).

Cure rates for aggressively staged, resected, pathologic Stage I lung cancer are 60%-90% (1,3). For resected pathologic Stage II disease, the cure rate decreases to 30%-50% (1,3), reflecting the negative influence of lymph node involvement.

Patients with metastatic disease (Stage IV) are incurable and chemotherapy has shown minimal benefit (1). Life expectancy for this group of patients is approximately six months and optimizing the quality of survival is the main objective when caring for these patients.

Most patients with Stage III lung cancer are unresectable (1,3) and radiation therapy is standard treatment. These patients can be expected to achieve one, two and five-year survival rates of approximately 40%, 20% and 5% respectively (1,4,5,6).

Based on resectability, Stage III lung cancer is divided into III A (potentially resectable) and IIIB (unresectable) subgroups (7). Although most patients with Stage IIIA disease will ultimately not be candidates for resection based on tumor extent and/or clinical grounds (general health, lung function etc.)(3,8), some carefully selected patients will be able to undergo total resection of gross cancer. This results in a better survival for Stage IIIA patients as a group when compared with Stage IIIB patients (7,9), who are all unresectable.

This paper analyzes our results for treating a selected group of unresectable Stage III (IIIA & IIIB) lung cancer patients with aggressive irradiation alone.

Methods and materials

A total of 378 patients with a diagnosis of lung cancer (both small and non-small cell, all stages) were seen in the Department of Radiation Oncology at WVU in Charleston from 1/1/84 - 1/1/87. Of these patients, 112 were individuals with previously untreated Stage III NSCLC. From this group, those who met the following criteria were selected for our study: a) no supraclavicular adenopathy; b) no pleural effusion; c) aggressive ($\leq$ 5,000 rad) radiation treatment; d) at least a fair (Karnofsky $\geq$ 60) performance status; and e) no chemotherapy before, after or during radiation.

After these exclusions, 50 Stage III patients remained and we utilized these individuals for our study because we felt they would have a reasonable chance for extended survival when treated only with aggressive irradiation. Charts were reviewed in July 1989 and the status of the surviving patients was updated December 1, 1990. Survival curves were calculated from the date of diagnosis using the Kaplan-Meier Method. Differences in survival at specific times were compared for statistical significance by the Chi-Square test. Minimum follow-up was four years.

All patients in this study received at least 5,000 rad (range 5,000-8,500, median 5,500). Daily radiation doses varied from 150 to 400 rad, with most patients receiving 250 rad-300 rad per day. All but two of these patients were given a two to three week break midway through treatment.

Forty patients (80%) were treated with a posterior spinal cord block throughout their second half of therapy as a means of keeping the spinal cord dose within acceptable

Table 4. **Characteristics of Potentially Cured Patients**

Patient	Histology	TNM_0	How T was Determined	Stage	Dose (rad)	DFS
GD	PD Large Cell	T_4N_0	Thoracotomy	IIIB	6000	6 yrs
WC	PD SCC	T_4N_0	Bronchoscopy	IIIB	6500	5 yrs 1 mo
JT	WD SCC	T_3N_0	Chest Xray	IIIA	5000	6 yrs 2 mo

Abbreviations: PD=Poorly Differentiated, WD=Well Differentiated, SCC=Squamous Cell Carcinoma, DFS=Disease Free Survival.

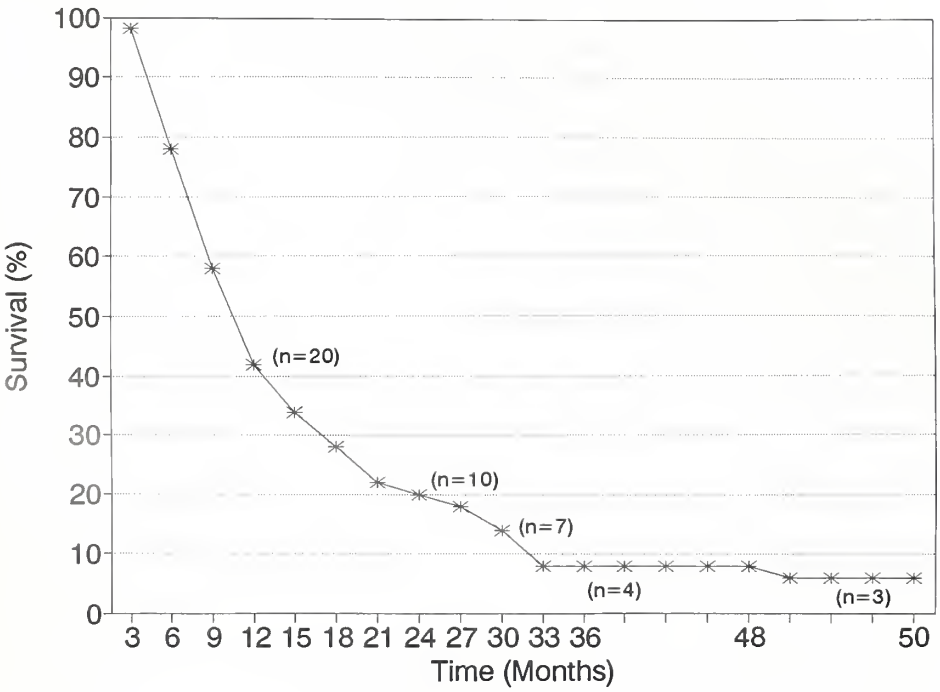

Fig. 1. Survival for the Group (50 Patients)
(n=Number of Patients Alive)

limits. This was accomplished in the other 10 patients by use of oblique fields or excluding the mediastinum from the radiation field during the second half of therapy.

Results

The 50 patients in our study included 37 males and 13 females with a median age of 67 years. Degree of tumor differentiation was specified in 37 patients and 70% of these were poorly differentiated tumors. Table 2 shows the patient distribution by TN classification and stage subgrouping. Twenty-one patients were node positive and all but two of them had N2 disease.

Figure 1 shows survival for the entire group. Median survival was 10 months, and one, two, three and five-year survival rates were 42%, 20%, 8%, and 6% respectively.

Table 2 reveals that 28 patients had Stage IIIA disease and 22 patients had Stage IIIB disease. Survival curves for these two groups of patients are shown in Figure 2. At 12 and 18 months, survival was approximately 18% better for Stage IIIA patients, but this was not statistically significant (Table 3). At two years and beyond, the survival curves were essentially identical with approximately 5% of both Stage IIIA and Stage IIIB patients alive and cancer free at five years.

Three patients were alive and cancer free at the time of analysis. All had survived more than five years since diagnosis and are potentially cured (Table 4). Note that all three were node negative. In contrast, only one node positive patient (T_3N_2) survived more than three years.

A total of 32 of our patients could be evaluated for their initial site of cancer recurrence. Local (within the radiation field) failure only was the initial site of cancer recurrence for 15 patients (47%). For specific histologies, 50% of squamous cell carcinomas and 38% of adeno/large cell carcinomas initially had local failure only as the first site of recurrence.

Discussion

This paper analyzed the results of treating a selected group of patients with unresectable Stage III (locally advanced non-metastatic) lung cancer with irradiation alone. Since the overall prognosis for these patients is poor, we selected a subgroup that had prognostic factors associated with improved survival (1) in order to evaluate the results of radiation treatment given in optimal circumstances. Good performance status and weight loss less than 5% are two factors that have consistentl been shown to double median survival when compared to similar staged patients without these favorable factors (1,5,6). We had hoped to include only patients with these characteristics in our study, but our data was not detailed enough for us to do this. Alternatively, we were able to identify and exclude patients with a poor performance status (Karnofsky $\leq$ 50), pleural effusion, supraclavicular nodes, and radiation dose < 5,000 rad. We felt that these exclusions would yield a group of patients with a reasonable chance for long-term survival when treated by aggressive irradiation. Fifty patients met this criteria and formed the basis for our study.

Our patients achieved 1, 2, and 5-year survival rates of 42%, 20%, and 6% respectively (Figure 1). This is similar to what is reported in the literature (1,4,5,6) and emphasizes the fact that radiation alone will produce significant one and two-year survival rates for selected patients with Stage III lung cancer. In addition, approximately 5% of patients will be cancer free and potentially cured, five years after treatment with radiation. Consequently, it is our opinion that

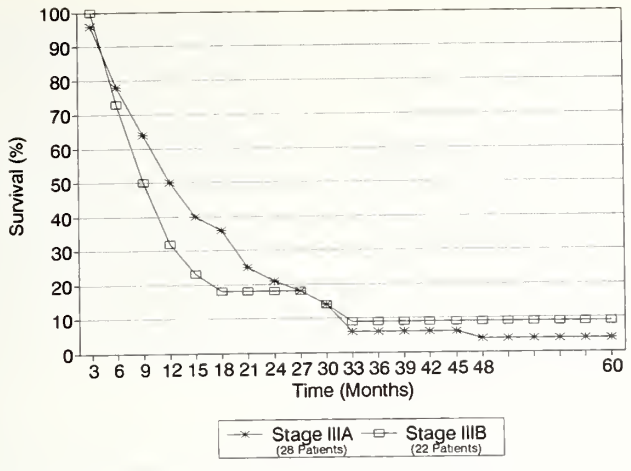

Fig. 2. Survival, Stage IIIA vs Stage IIIB

withholding radiation treatment for asymptomatic Stage III lung cancer patients solely on the grounds that they are incurable is not valid.

Three of our patients were cancer free more than five years after diagnosis (Table 4). All of these patients were node negative. A posterior spinal ord block was used on most of our tients throughout their second half therapy. At the time, this was an cepted and commonly-used atment technique to keep the diation dose to the spinal cord within ceptable levels. However, it also creases the dose to the mediastinal odes.

We feel that this decreased ediastinal dose, at least in part, ccounts for the fact that none of our atients with nodal involvement were 5-year survivors, and only one patient with nodal involvement lived more than three years. Other reports have shown that a small percentage of patients with mediastinal node involvement will be free of disease five years after treatment with irradiation (4,5). Techniques for keeping the dose to the spinal cord within acceptable limits without decreasing the dose to the mediastinal nodes have been standard practice in the Department of Radiation Oncology at WVU in Charleston since 1988.

Stage III lung cancer is subdivided into IIIA (potentially resectable) and IIIB (unresectable) subgroups (7,9). Our data (Figure 2) showed no statistically significant difference in survival for patients with Stage IIIA and IIIB disease treated with radiation alone. A similar, but much larger study from the University of Pennslyvania (6) also found no difference in survival for Stage IIIA and IIIB patients treated with irradiation.

Based on these initial studies, it would appear that irradiation yields equivalent survival rates for Stage IIIA and IIIB patients. This is not surprising since the subdivision of Stage III lung cancer was based entirely on surgical resectability. However, additional studies wil be needed before this finding can be accepted or rejected.

Although recurrence within the radiation field is more common for squamous cell than it is for adeno or large cell carcinoma (1,4), control of the primary tumor continues to be a major problem for all histologies when Stage III lung cancer is treated with irradiation. With a median dose of 5,500 rad, the primary tumor site alone was the initial site of failure for 47% of our evaluable patients. In the University of Pennsylvania study, Curran and colleagues (6) reported that with a median dose of 5,900 rad, the primary tumor site was the first site of failure for 45% of their patients. For Stage IIIA patients receiving 6,000 rad, Perez (4) reports that local failure was a component of the initial site of relapse in 40% of patients.

With 40%-55% of patients initially failing in the radiation field (1,4,6), it would seem that better local tumor control would translate into improved survival rates. In hopes of achieving this, a study has been instituted with patients receiving radiation twice, rather than the usual once per day. This treatment technique allows delivery of higher radiation doses than can be delivered with standard once daily treatment. Preliminary results from this study are encouraging with 20% of Stage IIIA (all N2) patients disease free at three years as compared to 7% of similar patients treated in standard one treatment per day fashion (5).

Due to the high propensity for patients with Stage III lung cancers to develop distant metastasis, improved local control will, most likely, provide only modest gains in survival rates. Significant improvement in survival rates will only occur when effective systemic therapy is developed. Unfortunately, chemotherapy has shown only minimal benefit for non-small cell lung cancer (1). Current protocols are combining radiation with chemotherapy hoping to obtain a synergistic effect on survival rates for patients with Stage III disease.

Summary

Approximately 1/3 of non-small cell lung cancer (NSCLC) patients present with locally advanced, non-metastatic disease (Stage III). Based on resectability, Stage III disease is divided into Stage IIIA (potentially resectable) and Stage IIIB (unresectable) subgroups.

Most patients with IIIA disease turn out to be unresectable and all patients with IIIB disease are unresectable. Standard treatment for unresectable patients is radiation therapy. Based on initial data, it appears that survival rates for patients with Stage IIIA or Stage IIIB disease are similar when treated with irradiation.

Radiation treatment alone can be expected to yield one and two year survival rates of 40% and 20% respectively for Stage III NSCLC patients. Although overall prognosis remains poor for this group of patients, approximately 5% of selected patients with Stage III disease will be cancer free and potentially cured, five years after treatment with irradiation. Consequently, we feel that withholding radiation treatment for asymptomatic Stage III (NSCLC) patients solely on the grounds that they are incurable is not valid.

Recurrence within the radiation field continues to be a major problem for patients with Stage III NSCLC, accounting for the initial site of failure in 40%-55% of patients. Improvements in local control will likely improve survival rates somewhat, but, because of the marked propensity for these cancers to ultimately develop metastatic disease, significant improvement in survival rates will only occur when effective systemic therapy is available. Unfortunately, none exists at this time.

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Serum ferritin and myocardial infarct

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Abstract

In a recent Finnish study, an association of high serum ferritin levels with excess risk of myocardial infarction in men was reported. This was the first such report in the literature so we decided to review the clinical records of 298 male patient seen over a 10-year period in Southern West Virginia, in whom serum ferritin levels were obtained. Of the 32 patients who experienced an acute myocardial infarction, there were no significant statistical differences between their mean ferritin levels and the ferritin levels of the 266 patients with no myocardial infarct. Only two of the 32 patients with myocardial infarct showed an elevated serum ferritin level, so our findings do not support the hypothesis that high serum ferritin levels are associated with myocardial infarct.

Introduction

In a recent issue of *Circulation*, there appeared a clinical study report by Salonen et al, entitled: "High stored iron levels are associated with excess risk of myocardial infarction in Eastern Finnish men" (1). The investigators from the Research Institute of Public Health, University of Kuopio, Finland, concluded that the results of their prospective study suggested that a high ferritin level is a risk factor for coronary heart disease.

Their study population consisted of 1,931 normal, healthy Finnish males ages 42-60, who were followed for five years. Of these men, 51 experienced an acute myocardial infarct (MI) during an average follow-up period of three years. Men with a serum ferritin level above 200 ng/1 had a 2.24 times higher risk factor for acute myocardial infarct than those with serum ferritin levels below 200 ng/1.

These researchers also found a statistical correlation between elevated serum ferritin levels and blood glucose, triglyceride concentration and systolic blood pressure readings. A sub group of 677 other males with "prevalent coronary heart disease," as defined by a history of previous MI or angina pectoris, were excluded from their analysis.

This interesting report, which appeared to be the first of its kind linking high ferritin levels to myocardial infarct in men, prompted us to review the charts of all male patients seen during the past 10 years in an outpatient setting in a small rural West Virginia community.

Methods and materials

We reviewed the charts of 298 male patients for whom complete records were available from a physician in general practice. These individuals were mainly from two Southern West Virginia counties with a high number of mine workers who had been exposed to mine dust. All patients were followed for periods from 1-10 years with a mean of 5.16 years.

Every patient had a complete physical examination, a 12-lead electrocardiogram; a chest X-ray; and a chemical profile consisting of glucose, blood urea nitrogen, creatinine, total cholesterol, triglycerides, calcium, phosphorus, sodium, potassium chloride, uric acid, total protein, albumin, globulin, and A/G ratio, total bilirubin, alkaline phosphatase, LDH, SGOT, SGPT, GTT, ionized calcium, thyroid profile (consisting of T3 uptake, T4 total, and T7), complete blood count with differential, leukocyte count, lipid profile (HDL cholesterol, LDL, VLDL); and serum ferritin levels taken at the beginning and end of the period of observation.

Serum ferritin was determined by the Magic Ferritin (125) Radio-immunoassay procedure which employs constant amounts of two antibodies, one covalently coupled to paramagnetic particles and the other radioiodinated. The normal range for this method is 7-350 ng/l, with a mean of 51 ng/l for males. All myocardial infarctions were documented by electrocardiographic and other evidence obtained in the office and from hospital records.

All blood samples were obtained while the patients were fasting. None of these patients were taking any iron-containing preparations, and no information was routinely recorded about their smoking habits.

Results

There were 298 male patients in our study population and their clinical diagnoses are summarized in Table 1. Their serum ferritin levels ranged from 11 to 900 ng/l, with a mean of 155.9, S.D. 63.6 (Table 2).

Acute myocardial infarction occurred in 32 of the 298 patients during the period of observation; and four of these were fatal. There was no significant statistical differences between the mean serum ferritin level of the 32 patients with myocardial infarct and the 266 patients with no myocardial infarct ($P = 0.23$). Only two (or 6.3%) of the 32 patients with myocardial infarct had a serum ferritin level exceeding 200 ng/l, i.e. 262 and

TABLE 1. Multiple Diagnoses of 298 Male Patients Seen By a General Practitioner in Southern West Virginia

Chronic obstructive lung disease	162	Valvular heart disease	6
Hypertension	80	Nephrolithiasis	5
Coronary insufficiency/Angina	47	Diverticulosis	5
Peptic ulcer/Reflux	43	Hyper/Hypothyroidism	5
Arthritis	40	Stroke	4
Hyperlipidemia	38	Seizure disorder	4
Acute myocardial infarction	32	Hernia	4
Diabetes	30	Psoriasis	3
Lumbosacral spine syndrome	24	Gout	3
Peripheral vascular disease	12	Aneurysm	3
Cardiac arrhythmia	10	Osteoporosis	3
Alcoholism	9	Alzheimer's disease	2
Prostatic hypertrophy	9	Gilbert's Syndrome	1
Carcinoma	6		

Table 2. Ferritin Levels

	Number of Patients	Mean Ferritin Level	St. Dev.	Range
All males	298	155.9	63.6	11 to 990
M.I.	32	147.8	65.0	18 to 378
No M.I.	266	156.9	63.5	11 to 990

No significant difference between the mean for patients with M.I. and the mean with no M.I. (P = 0.23)

Ferritin Levels above v. below 200 n/ml

	Below 200 n/ml	Above 200 n/ml	
Patients with M.I.	30	2	32
Patients with no M.I.	223	43	266
	253	45	298

Table 3. Comparison of Initial and Final Ferritin Levels

	Number	Mean	St. Dev.
Initial	297*	159.8	46.6
Final	297	153.6	111.7
Difference	297	6.21**	116.7

* One patient with fatal M.I. had only one observation

** No significant difference (P = 0.48)

Table 4. Ferritin Level by Age

Age	Ferritin Level	Number of Observations
30 - 39	172.4	46
40 - 49	161.7	180
50 - 59	157.8	154
60 - 69	151.9	133
70 - 79	146.4	82
80 - 89	119.0	6

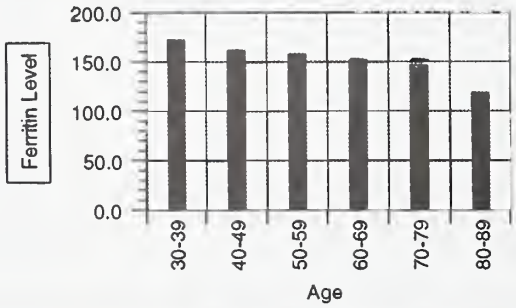
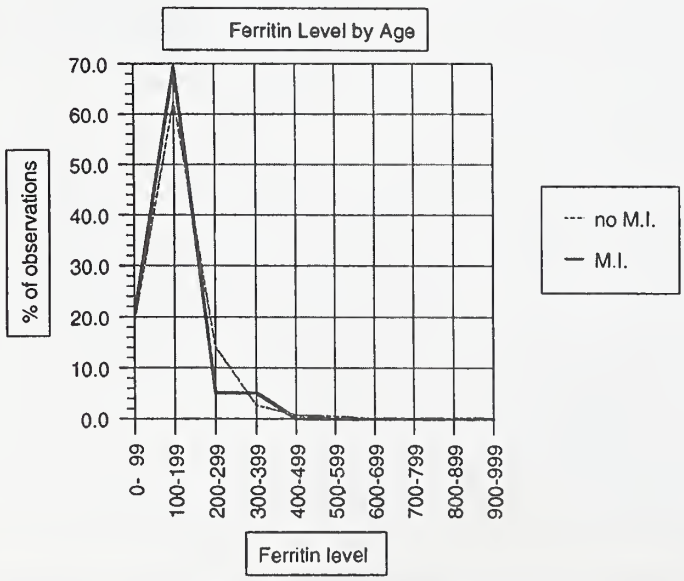


Table 5. Ferritin Levels – All Observations N = 600

Ferritin Level	Number of Observations No M.I.	M.I.	Ferritin Level	Percent of Observations No M.I.	M.I.
0 - 99	107	8	0 - 99	19.1	20.5
100 - 199	351	27	100 - 199	62.6	69.2
200 - 299	79	2	200 - 299	14.4	5.1
300 - 399	15	2	300 - 399	2.7	5.1
400 - 499	4	0	400 - 499	0.7	0.0
500 - 599	3	0	500 - 599	0.5	0.0
600 - 699	0	0	600 - 699	0.0	0.0
700 - 799	0	0	700 - 799	0.0	0.0
800 - 899	1	0	800 - 899	0.2	0.0
900 - 999	1	0	900 - 999	0.2	0.0



378 ng/l respectively. This contrasts with 43 (or 16.2%) of the patients who did not experience a myocardial infarct (Table 2).

There was no significant difference between initial and final serum ferritin levels (Table 3). In addition, Table 4 shows ferritin levels by age groups and the level decreases with age, as observed in other limited population studies (1,3,4,5).

Table 5 compares ferritin levels in the two groups of patients. The small differences observed were not statistically significant.

Statistical method

Student's t-tests for large samples were used to test for differences between means, and the Pearson product-moment correlation coefficient was used to compare variables. All P-values shown are for one-tail tests.

A single ferritin level was assigned to each patient for the purpose of comparing the ferritin level of patients who experienced myocardial infarction with the ferritin level of those who did not experience myocardial infarction. The mean of all observed ferritin levels for a single patient was assigned to those 266 patients who did not experience myocardial infarction. For the 32 patients who experienced myocardial infarction, the mean of only the ferritin levels observed at time of the episode was assigned.

Discussion

Analysis of our data shows some dramatic differences from those reported by Salonen and colleagues.

For example, in the Finnish study, the mean serum ferritin level for 1,931 subjects was 166 ng/l, with a S.D. of 149 and a range of 10-2270 ng/l. The mean serum ferritin level for the 51 subjects who developed myocardial infarction were significantly higher than that (exact numbers were not given). The Finnish researchers also found a 2.2-fold increase risk for

myocardial infarct among their subjects with elevated serum ferritin levels above 200 ng/l.

By comparison, our data for all 298 patients showed a mean serum ferritin level of 155.9 ng/l, with a S.D. of 63.6, and a range of 10-900 ng/l. The mean serum ferritin level of 32 patients with myocardial infarct was 147.8 with a S.D. of 63.5 and a range of 50.5-378 ng/l. There was no statistically significant difference between the two groups, (P = 0.23).

It is also interesting to compare our mean serum ferritin levels with those vailable from limited population tudies in the literature. Herbert (2) eported that the average American nale, ages 18 to 64 years, has a serum .erritin level of about 80 ng/l. Lipschitz et al. (3) found the mean male plasma ferritin level to be 100 ng/l with a S.D. of 60. Cook et al. (4) reported the median serum ferritin level in the State of Washington for 1,564 males ages 18-45 to be 94 ng/l. Johnson et al. (5), in an Icelandic random population study of 925 males ages 25-74, found a mean level of 198 ng/l.

We conclude that we have been unable to confirm an association between high serum ferritin levels and the occurrence of myocardial infarction.

Conclusion

A retrospective analysis of the clinical data of 298 male patients, followed over a period of up to 10 years, failed to show any correlation between high serum ferritin levels and acute myocardial infarct. Admittedly, both the Finnish prospective study in healthy males and this retrospective analysis in outpatients represent only small pilot studies.

Large scale clinical evaluations are needed to provide further evidence of any possible association between serum ferritin levels and coronary heart disease.

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4. Cook, JD, et al. Estimates of iron sufficiency in the U.S. population. Blood 1986;68:726-31.
5. Johnson et al. Prevalence of iron deficiency and iron overload in the adult Icelandic population. J Clin Epidemiol 1991;44:1289-97.

Manuscript Guidelines

All scientific manuscripts should be submitted on an IBM compatible disc in Wordperfect 5.1 or in ASCII (generic). They must be prepared in accordance with *"Uniform Requirements for Manuscripts Submitted to Biomedical Journals."*

Papers will not be considered for publication if they have already been reported in a published paper or are described in a manuscript submitted or accepted for publication elsewhere. They should be accompanied by one extra copy, be double-spaced on white bond paper, and have the page numbers printed in the right-hand corner of each page.

All manuscripts should include:

1. Title page
2. An abstract of no more than 150 words
3. Text
4. Acknowledgements
5. References in parentheses numbered consecutively. No more than 25 references will be published free of charge.
6. Tables
7. Legends for illustrations

All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the concept.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing its most commonly known trade name.

Tables (tabular listings) and figures (photos, drawings and charts) should be numbered, and the point of reference in the text indicated in parentheses, i.e. (Table 1), (Figure 10). Photos must be unmounted glossy prints in a 5 in. x 7 in. format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be done in solid black on pure white.

All scientific material is reviewed by the Publication Committee and should be sent to The Editor, West Virginia Medical Journal, P.O. Box 4106, Charleston, WV 25364.

President's Page

James L Comerci M.D.

When a reporter calls, call back!

Communicating with the media can be both a rewarding and a frustrating experience. Both the reporter and physician are under significant pressures of time to get their jobs accomplished. It is important though, that we as physicians, realize the deadline pressures reporters are under and always give them the courtesy of a response as quickly as possible.

Unfortunately, as a profession, it appears that we fail to show the news media the proper respect by not returning their phones calls. This fact was brought to my attention recently after reading a letter which Therese S. Cox, the medical reporter for the *Charleston Daily Mail,* wrote to the editor of the *Journal* Dr. Stephen Ward. This letter is printed on the opposite page and I hope each of you take the time to read it because Ms. Cox's comments provide a valuable insight into the difficulties reporters face when dealing with physicians.

In her letter, Ms. Cox poses a question which shows just how frustrating it is for reporters to try to interview physicians -- "How can I responsibly communicate doctors' words to the public when they won't call back?" We obviously need to make drastic changes in the way we interact with the media because improving our communication and trust can only help to improve our public image.

There have been problems between the news media and physicians for years, and a recent study by the Freedom Forum First Amendment Center at Vanderbilt University written by Dr. Harrison L. Rogers, a past president of the AMA, and Rita Rubin, former medical reporter for the *Dallas Morning News,* revealed just how extreme this communications gap has become. The study stated "To the positive points raised by one side, there are negative responses from the other. Doctors don't trust the news media; the news media don't trust doctors. Our research suggests that on no other newsroom beat — including business, where the disenchantment is palpable — is there such an atmosphere of mutual mistrust."

The study made recommendations to journalists, to doctors and to academic institutions about how to improve relations between the media and physicians. The recommendations to doctors are as follows:

* Physicians and researchers should be as accessible to the press as their schedules allow, keeping reporters' deadlines in mind.
* Doctors who expect to have contact with the press should seek training in order to better understand reporters' needs and constraints.
* Physicians should discuss ground rules concerning on/off-the-record comments and the right to review quotes before, not after, interviews begin.
* Medical researchers presenting papers at scientific meetings should discuss their presentations with reporters.
* If reporters don't get medical stories right, physicians should let them know. If corrections are not forthcoming, physicians should let the public know.

I hope each of you will take these suggestions seriously and do your part to improve media relations. So, next time a reporter calls, call back!

James L. Comerci, M.D.

A special message about media relations

Stephen D. Ward, M.D.
Chairman, Publication Committee
West Virginia Medical Journal
4307 MacCorkle Avenue, S.E.
Charleston, WV 25304

Editor:

I write about health for the Charleston Daily Mail newspaper.

I respect and often seek the advice and opinions of your colleagues. What better way is there to educate our readers on health issues?

However, the exercise of reaching physicians on the phone can be fraught with frustration.

I realize they are quite busy. But deadlines are a fact of journalism. How can I responsibly communicate doctors' words to the public when they won't call back? Readers would be so much better informed if I could include the comments of a respected physician, whether the story was of the news or feature variety. A call back would be most appreciated.

By the way, these comments do not apply across the board. A few Charleston physicians have been very accommodating. And your president, Dr. James Comerci, always shows utmost consideration.

Thank-you.

Warmly,
Therese S. Cox

Dear Ms. Cox:

Doctors are really timid souls, easily frightened, particularly by reporters and prone to a form of late onset stage fright (perhaps a slow virus) brought on by seeing their name in print. Once inoculated by the virus, however, they seem to recover with lifelong immunity but occasionally with an unfortunate lifelong compulsion to write letters to the editor.

I suffer from a particularly virulent form of this strange compulsion.

Best regards,
Stephen D. Ward, M.D.
Editor

(Please see Dr. Comerci's message on the opposite page about the importance of interacting with the media.)

In My Opinion

Clinton's health care plan deserves praise, much criticism

In President Clinton's health reform plan, there are some points to praise but much to condemn. First, he deserves praise just for tackling this complex subject. The 1,342 page bill now before Congress attests to its complexity; before the election, he felt it would take just nine hours of his time to reform health care.

Secondly, I think President Clinton is right on the matter of employer mandates, even though most of my colleagues on the Legislative Committee of the WVSMA oppose this. They feel it is an unwarranted intrusion into the employer-employee relationship, and while that is true for a purist in the 18th century, the same can be said of the minimum-wage laws and all other features of labor law.

I feel employee mandates are right for the following reasons:

1. It is a uniquely American solution. Tying health insurance to employers began after WWII, as benefits were fully deductible, and not taxable to the employer. European, Japanese, and Canadian patients look to their governments, not their employers.

2. Workers comprise 54% of the uninsured, and an additional 27% (81% total) are dependents of workers. Having some employers provide benefits, while others do not, creates unfair competition, favoring the irresponsible.

3. The system has been tried in Hawaii for over 20 years, and it works there by keeping the uninsured to about 3%. Businesses in Hawaii cannot escape over the borders, and to be effective, the plan must be national in scope, not state-by-state.

4. Though some prices will rise, the effects will be uniform across an industry, and no one will gain an advantage by short-changing his/her employees.

The third point I agree with the president about is phasing out Workers' Compensation and the health insurance part of automobile insurance. A broken leg is a broken leg, whether you get it skiing, working, or in an automobile accident. The treatment is the same, and if all are covered, there is no need for these duplicative programs.

The last item the president is right about is universal coverage. This is perhaps the major issue on which the president and the medical profession agree -- that every patient should have access to medical care. He has indicated that it is the only non-negotiable point of his program.

Where, then, is the disagreement? The plan is so complex, so radical in restructuring, and so bureaucratic in nature that it throws out the baby with the bath water, destroying the good as well as the bad.

To begin, consider the National Health Board. It is set up above the laws. When they set fees or spending caps, there is no possibility of congressional or judicial review. Who wrote this -- Joseph Stalin? The president and the Congress are not above the law; why should the National Health Board be? All that is required of a deity is that they be omnipotent, omnipresent, omniscient, and possessing eternal life, and these are granted. Perhaps deification will await a second term since it's so hard to get through Congress.

Secondly, large bureaucracies (health alliances) are created. The author of *"Managed Competition"* is Alan Einthoven. He envisioned health alliances as being associations of smaller businesses, pooling their purchasing power. He never envisioned them as governmental agencies, setting prices and fees and dictating to providers. Like Frankenstein, he now disclaims and opposes what he played a role in creating, because, as an economist, he recognizes that price controls have a 4,000 year history of failure, producing only shortages, rationing, black markets and destruction of the market.

The third criticism I have with the plan is the fact that solo practice seems an endangered species. Large networks seem the order of the day. Germany, England, Canada and Japan have not found it necessary to ban solo practice; the Soviet Union did. Is this the model? Even the Congressional Budget Office admits that there is no proof that "Managed Care" saves a dime. If not, why force all practitioners into this pattern? President Clinton pays only lip service to abolition of the micromanagement of insurance companies, but replaces it with a worse system of micromanagement by bureaucrats whose only yardstick is the annual cost.

Another problem with the plan is that it will worsen the practice of medicine by requiring that 50% of practitioners be primary care physicians who will care for almost all conditions. OB-GYN physicians have lobbied to be considered primary care physicians, and have won this concession. They are, for many women, the only physician they see. But, when the woman who sees her OB-GYN physician has a myocardial infarction, the guidelines will mandate that the OB-GYN physician takes primary responsibility unless complications arise.

My fifth objection is that the plan makes no provision for advances in medical science. When an AIDS vaccine appears, it would be given to a large number of people, and be temporarily inflationary. No more; if it be given it must displace something else, such as DPT immunization, or polio, in order not to be inflationary.

Senator Rockefeller has criticized us for tepid support of the bill. He wants zealots, voting yes for every one of the 1,342 pages, no matter how offensive, or wrong. There is no Hippocratic Oath to participate in the

destruction of a proud profession with 3-4 millennia of honorable service to mankind. I used to rail at the agencies that sent me letters "Dear Provider." "I'm not a provider, damn it, I'm a physician, a doctor." If the Clinton bill passes, I'll have to say, "I'm not a doctor -- I'm just a provider."

I'm not defending the status quo because in many instances the status quo stinks, particularly in the role of the health insurance companies. We desperately need health insurance reform to reform the cherry-picking, the absolute risk avoidance, to make policies portable, to eliminate the exclusion of prior conditions, and the irrational rating of totally benign disorders. But, we must build on the strength of our present system -- the dedication and professionalism of the medical profession and ancillaries, the finest system in the world for provision of care, and seek to improve only the problem areas. We must restore market forces to medical care through medical IRAs (proven to work in Singapore, whereas, the president's plan is completely untried and unproven).

A sixth issue I feel must be challenged is the matter of privacy. To enlarge support for the bill, privacy issues are submerged for the first few years. As a consequence, sensitive medical data will be protected only after being widely distributed. Your sexual preferences, fears, fantasies, defecatory practices, partners, and diseases will all be public knowledge before they are protected.

Funding for this bill is my major concern. To believe the president's figures, you have to first believe in the Tooth Fairy, the Easter Bunny and Santa Claus as major funding sources. If you can do that, you can envision an extra 37 million people insured, expanded benefits, and no new taxes unless you are addicted to cigarettes. Money will be taken from Medicaid and Medicare as well. No matter that hospitals are already losing billions on these programs now, and are only existing because of cost-shifting. Every dollar sucked from these programs will only increase the loss, and since cost-shifting will be eliminated, bankruptcies will follow.

This is no time for the summer soldier and the sunshine patriot. We are under seige, and we must man the ramparts. We should not be afraid to speak up on these matters in which we, not the politicians, are the experts. We should seek to modify the bill, keeping in mind our single mission to save our patients' health. If it is not possible to modify the bill, we should commit to the defeat of the bill, our lives, our fortunes, our sacred honor.

Wallace D. Johnson, M.D.
Beckley, WV

You are cordially invited to attend the

West Virginia State Medical Association's

Legislative Briefing & Reception

February 14, 1994

Briefing: 3:30 - 5:30 p.m.

Reception: 6 - 8 p.m.

Charleston Marriott

Please R.S.V.P. by February 11

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Cancer crosses all cultures and all nationalities without exception. So it stands to reason that the treatment and eventual cure of a condition experienced worldwide would require talent and intellect from around the globe.

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At Mid-Winter

Third Session to feature topics on environmental medicine, patient communication issues

Since the public views physicians as the most trusted source of information regarding environmental health issues, this year's Third Scientific Session at the WVSMA's Mid-Winter Clinical Conference at Lakeview Resort and Conference Center in Morgantown is entitled *"Symposium on Environmental Medicine and Patient Communication."*

Set for Saturday, January 22 at 2 p.m., this Third Scientific Session is being co-sponsored by the WVSMA and the National Institute for Chemical Studies in Charleston (NICS). The moderator for this symposium will be Susan L. Santos, M.S., research program director of the Columbia University Center for Risk Communication in New York City, who is also the principal and owner of an environmental consulting firm called Focus Group.

This session will begin with a presentation on *"The Physician as a Source of Environmental Information for Patients and Communities"* by Ms. Santos and David B. McCallum, Ph.D., principal of the Washington, D.C. branch of Focus Group. Following this first segment of the program, John D. Spengler, Ph.D., a professor of environmental health sciences and director of the Exposure Assessment and Engineering Program at Harvard University's School of Public Health, and Gregory R. Wagner, M.D., director of the Division of Respiratory Disease Studies for the U.S. National Institute for Occupational Safety and Health in Morgantown, will discuss *"Acute and Chronic Effects of Environmental Exposure to VOCs in the Kanawha Valley."*

After a short break, the meeting will convene with a lecture on the subject of *"Community Implications of Environmental Exposures and Information: A Physician's Perspective"* by Mary F. McDaniel, M.D., manager of Environmental and Community Medicine for Unocal Corporation in Los Angeles. The final panelist for the symposium will be Alan Ducatman, M.D., a professor of medicine and director of the Institute of Environmental Health at the West Virginia University School of Medicine. Dr. Ducatman will talk about *"Environmental and Occupational Health Issues Facing Physicians,"* and then a question and answer session is scheduled with all the panelists.

Santos

Wagner

McDaniel

Ducatman

Brief biographical information about these speakers begins below. **If you have not yet registered for the WVSMA's Mid-Winter Clinical Conference, you may phone in your reservation by calling the WVSMA at (304) 925-0342 by noon on Wednesday, January 19, or you may register at the door.**

Lecturers highlighted

Ms. Santos provides consultation in the areas of risk communication and assessment in her current roles as research program director for Columbia University's Center for Risk Communication, and as the principal and owner of the firm Focus Group, based in Medford, Mass.

Prior to her appointment at Columbia and starting Focus Group, Ms. Santos was corporate director for Risk Assessment Services with ABB Environmental. She has over 15 years of environmental experience in the public and private sectors including over eight years at EPA Region I, primarily in the areas of toxic chemical and hazardous waste management.

A specialist in the design, implementation, and evaluation of risk and environmental issue-oriented information and education programs, Ms. Santos has developed communication strategies for hazardous waste sites, impact assessments, and community and worker right-to-know programs. She has planned and participated as a risk communication practitioner in nearly 200 public meetings, hearings, citizen briefings and workshops on behalf of government and industry.

Mrs. Santos received her undergraduate degree in chemistry and sociology at Boston College and her graduate degree in civil engineering and public health from Tufts University, where she is currently an instructor in the Hazardous Materials Management M.S. Program. She has written numerous publications about risk communication and assessment, including a report entitled *"Comparative Study of Risk Assessment and Risk Communication Practices between Western Europe and the United States,"* for which she received a German Marshall Fund Fellowship Award in 1989.

Dr. McCallum received a B.S. degree in chemical engineering from North Carolina State University in 1967, an M.S. degree in chemical engineering from the University of Virginia in 1970, and a Ph.D. degree in biomedical engineering from the University of Virginia in 1979. While pursuing his doctoral degree, Dr. McCallum worked as director of the Division of Early Disease Detection for the South Carolina Department of Health and Environmental Control in Columbia, S.C. After obtaining his degree, Dr. McCallum assumed another role for

his department as director of the Division of Chronic Disease Control.

From 1980-81, Dr. McCallum was program coordinator for the Medical Application of Research Section of the National Heart, Lung and Blood Institute of the NIH in Bethesda, Md. He then joined the faculty of Georgetown University Medical Center as an associate professor and director of the Program for Risk Communication. Dr. McCallum taught at Georgetown until 1990, when he was named a visiting professor of public health at Columbia University in New York City. In 1993, he assumed his current role at Columbia as an adjunct professor of public health and began acting as a principal for the Washington, D.C. branch of the consulting firm Focus Group.

A reviewer for the *Journal for Risk Analysis* and *JAMA*, Dr. McCallum is an accomplished author who has published extensively about health and environmental medicine issues. During his career, Dr. McCallum has served in a consultative capacity for many agencies of the federal government, including EPA and the F.D.A.

Dr. Spengler received a B.S. degree in physics in 1966 from the University of Notre Dame, a Ph.D. degree in atmospheric sciences in 1971 from the State University of New York at Albany, and an M.S. degree in environmental health sciences in 1973 from Harvard University. In addition to his current roles as a professor of environmental health sciences and director of the Exposure Assessment and Engineering Program at Harvard University's School of Public Health, Dr. Spengler has recently served as either a consultant or member on various EPA Science Advisory Board committees.

A member of the National Academy of Science's Committee on Risk Assessment of Hazardous Air Pollutants, Dr. Spengler is also a founding member of the International Society of Indoor Air Quality and Climate and the International Society of Exposure Analysis. He was one of nine international coordinators for the 6th International Conference on Indoor Air Quality and Climate held in Helsinki, Finland in July 1993.

Dr. Spengler has conducted research in the areas of personal monitoring, air pollution health affects, aerosol characterization, indoor air pollution and air pollution meteorology, and has published extensively about each of these subjects. His most recent book, co-authored with Dr. John Samet, is entitled *Indoor Air Pollution: A Health Perspective*. He is also serving on the editorial board for the new journal *Indoor Air*.

Dr. Wagner is responsible for conducting research, training, and public health response activities relevant to the prevention of occupational respiratory diseases in his role as director of the Division of Respiratory Disease Studies for the U.S. National Institute for Occupational Safety and Health. His division also conducts research, training, and public health response activities relevant to the prevention of occupational respiratory diseases, as well as mandated programs of surveillance for coal miners and training for physicians in the interpretation of X-rays for pneumoconiosis. Under Dr. Wagner's guidance, NIOSH has taken the lead in the U.S. effort to control or eradicate silicosis.

During his career, Dr. Wagner has been engaged in a variety of academic and clinical activities. He taught and practiced at the Marshall University School of Medicine in Huntington, where he was chief of the Division of Occupational and Environmental Health. Prior to this, Dr. Wagner practiced general internal and family medicine at the Cabin Creek Medical Center in Davis, W.Va.

Currently involved with the World Health Organization and the International Labour Organization in their efforts to establish harmonized guidelines for screening and surveillance of workers exposed to mineral dust, his present professional focus is the role of government in disease prevention. Dr. Wagner is board certified in internal medicine and in preventive (occupational) medicine, and is a certified B-reader for interpretation of X-rays for the pneumoconioses.

Dr. McDaniel received her B.S. degree in journalism from the University of Tulsa in 1971, where she also obtained her J.D. degree in 1976. After practicing law for five years, she attended medical school at Oklahoma State College of Osteopathic Medicine and received her D.O. degree in 1986. She served an internship at St. Michael's Hospital in Newark, N.J., and then returned to Oklahoma to complete a residency in occupational medicine at the University of Oklahoma, where she also obtained a master's degree in public health in 1988.

As manager of Environmental and Community Medicine for Unocal Corporation, Dr. McDaniel provides corporate support to staff and sets strategy for company policies on environmental health and safety. In addition, she works as a consulting physician for the firm Focus Group, providing risk communication planning and strategic intervention assistance for companies and community groups.

Board certified in occupational and environmental medicine, Dr. McDaniel is a member of the American College of Occupational and Environmental Medicine, the Society for Risk Analysis, the Society for Occupational and Environmental Health and the Western Occupational Medical Association. She is an adjunct lecturer for the University of California and often speaks at community meetings regarding health care issues.

Dr. Ducatman received an A.B. degree in analytical biology from Columbia College in New York in 1972 and obtained a M.Sc. degree in environmental health from City University of New York - Hunter College and the Mt. Sinai School of Medicine in 1974. He then attended medical school at Wayne State University in Detroit, where he graduated in 1978. He completed an internship at Brown University in Providence, R.I., and a medical residency and fellowship in occupational medicine at the Mayo Clinic.

From 1982-83, Dr. Ducatman was director of Occupational Medical Services for the U.S. Navy clinics at Columbia Park and Brooklyn Park, Minn. He then accepted another post for the U.S. Navy as director of the Professional Occupational Health Branch of the U.S. Navy Environmental Health Center in Norfolk, where he also was an assistant professor of community medicine at Eastern Virginia Medical School.

In 1986, Dr. Ducatman relocated to Cambridge, Mass., to become director of the Environmental Medical Service at the Massachusetts Institute of Technology. He moved to Morgantown in 1992 to assume his current role as director of the Institute of Occupational and Environmental Health at the West Virginia University School of Medicine, where he is also a professor of medicine.

Dr. Ducatman is a fellow of the American College of Occupational Medicine and of the American College of Physicians. He has co-authored a book and published numerous chapters, papers, and abstracts pertaining to occupational health and environmental medicine. Last year, Dr. Ducatman was awarded the Robert J. Hilker Award by the American College of Occupational and Environmental Medicine.

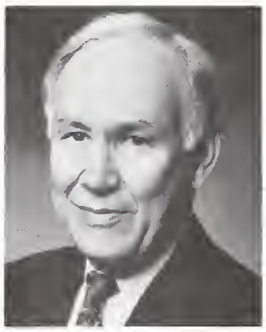
Clinton plan topic of Lunch and Learn

As a result of the two extremely successful Lunch and Learn programs which were presented during the WVSMA's Annual Meeting last August, another one of these events is planned for Saturday, January 22 at noon during the WVSMA's Mid-Winter Clinical Conference at Lakeview Resort and Conference Center in Morgantown. The topic for this Lunch and Learn will be "President Clinton's Health System Reform Plan: The Pros and Cons of the Plan and How It Will Affect the Physician/Patient Relationship."

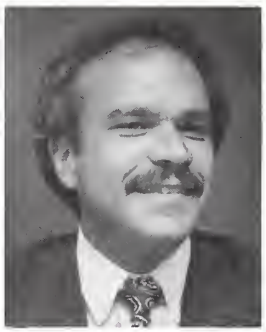
The panelists for this presentation will be AMA Trustee Dr. Randolph D. Smoak Jr.; WVSMA President Dr. James L. Comerci; and Dr. Robert M. D'Alessandri, vice president for Health Sciences and dean of the School of Medicine at West Virginia University. Dr. Smoak plans to discuss the AMA's recent decision regarding employer mandates; Dr. Comerci will be speaking about the managed care concept of the president's plan and how managed care is currently affecting his relationship with patients; and Dr. D'Alessandri will be discussing how medical schools in the state will be affected by the drive to increase primary care physicians, plus the effect on the training of specialists. The moderator for this session will be Dr. Robert Pulliam, WVSMA past president.

The cost for this program is $35 for WVSMA members and other physicians, and $20 for WVSMA Alliance members and other guests.

Brief biographical information about the three panelists begins below and more information about the Lunch and Learn can be obtained by contacting the WVSMA at (304) 925-0342.



Smoak



Comerci

D'Alessandri

Panelists highlighted

Dr. Smoak is a surgeon from Orangeburg, S.C., who was elected to the AMA Board of Trustees in June 1992. He served as secretary-treasurer of the AMA Physicians Health Foundation from 1992-93 and last year was appointed chair of the board's Subcommittee on Membership.

A graduate of the Medical University of South Carolina, Dr. Smoak served his internship at Grady Memorial Hospital in Atlanta and completed his residency training at the Medical University of South Carolina. After completing a senior surgical fellowship at M.D. Anderson Hospital and Tumor Institute in Houston, he returned to his home state of South Carolina to establish his surgical practice.

Elected to the South Carolina Medical Association's Board of Trustees in 1972, he has served in almost every leadership position including president of the SCMA; chair of the South Carolina Political Action Committee; president of the SCMA Members' Insurance Trust; and president of the South Carolina Medical Care Foundation. Dr. Smoak served as alternate delegate to the AMA House of Delegates for the SCMA in 1983, and as delegate in 1987. Since 1984, he has been on the AMPAC Board, elected secretary in 1986 and chair in 1988.

Dr. Smoak is a founding member of the South Carolina Oncology Society and is a fellow and governor of the American College of Surgeons. He is also a diplomate of the American Board of Surgery and an active member of the Southeastern Surgical Congress, the South Carolina Surgical Society and the South Carolina Chapter of the American College of Surgeons. In addition, Dr. Smoak is a clinical professor of surgery at the Medical University of South Carolina and a clinical associate professor of surgery at the USC School of Medicine.

Dr. Comerci became president of the WVSMA in August 1993. Born in Beckley, Dr. Comerci received both his B.A. degree in chemistry and his doctor of medicine degree from West Virginia University. He completed his residency in family medicine at Wheeling Hospital from 1980-83 and then went into private practice in Wheeling.

A member of the WVSMA since 1984, Dr. Comerci began serving on Council in 1987 and was named vice president in 1991, then president-elect in 1992. In addition to his positions on Council and the Executive Committee, Dr. Comerci served as program chairman of the WVSMA's Annual Meeting in 1990, and has been a member of the Legislative Committee since 1991.

Dr. Comerci is a member of the AMA and the Ohio County Medical Society, of which he was president in 1990. Board certified by the American Board of Family Practice, Dr. Comerci is also a clinical assistant professor of family medicine at WVU.

Very active in his local medical community, Dr. Comerci is a board member, a volunteer physician and a member of the Prenatal Care Committee at Wheeling Health Right; is a part-time team physician at Bethany College; and serves on the Utilization Review Committee at Good Shepherd Nursing Home.

Dr. D'Alessandri is a graduate of Fordham University and New York Medical College, who completed his postgraduate training at Metropolitan Hospital in New York and the

Lunch and Learn

University of Florida. A specialist in infectious diseases and general medicine, Dr. D'Alessandri is a fellow of the American College of Physicians and a diplomate of the American Board of Internal Medicine.

In his roles as vice president for Health Sciences and dean of the School of Medicine at West Virginia University, he is a member of several state and national task forces, committees and boards. He currently chairs the West Virginia Health Care Reform Project convened by Governor Caperton and Senator Rockefeller. He served on Hillary Rodham Clinton's Health Care Reform Task Force and was instrumental in organizing Mrs. Clinton's visit to WVU last year for the televised "West Virginia Speaks" health care forum.

Dr. D'Alessandri is a member of several national medical education groups and serves on the Executive Committee of the Accreditation Council for Graduate Medical Education as a representative of the American Association of Medical Colleges. He was selected as the recipient of the 1993 Medical Executive Award of the American College of Medical Group Administrators.

A regular guest commentator on West Virginia Public Radio, Dr. D'Alessandri appears each week as a medical correspondent on WCHS-TV. He also hosts *"Doctors on Call,"* a live public television broadcast that answers viewers medical questions.

Neri to perform variety of 50s, 60s music at Mid-Winter

Due to popular demand after his spectacular show at last year's WVSMA Mid-Winter Clinical Conference, Dr. Florencio "Jun" Neri will present a special musical variety act of songs of the 1950s and 60s on Saturday, January 22 at 8 p.m. during the WVSMA's Mid-Winter Clinical Conference at Lakeview Resort and Conference Center in Morgantown.

Dr. Neri, a general practice physician, is a native of the Philippines who is well known by his colleagues for his singing abilities. He has performed at many state and county medical meetings, as well at weddings, benefit concerts and other local events.

A 1969 medical graduate of Far Eastern University in Manilla, Dr. Neri did a three-year residency in general surgery in the Philippines

Neri

before continuing his postgraduate studies in general surgery at Long Island Jewish Hillside Medical Center in New York City. In 1975, he relocated to Welch, W.Va., where he worked at Stevens Clinic Hospital for three years before becoming an emergency physician at Princeton Community Hospital.

Since 1985, Dr. Neri has been in general practice in Princeton, where is still affiliated with Princeton Community Hospital. He and his wife, Shelby, are the parents of three children, Sheila, April and Christopher.

In addition to Dr. Neri's performance, Dr. Rano Bofill will be inviting guests to sing along with the laser-disk Karaoke machine he will be operating. This special entertainment is being presented in conjunction with a reception for all conference participants which begins at 7 p.m. and is being hosted by CNA Insurance Companies and McDonough Caperton (an Acordia Company).

BE THERE!

WVSMA / WV-ACP

1994 Mid-Winter Seminars and Scientific Conferences

January 20-23

Lakeview Resort and Conference Center
Morgantown, W.Va.

Phone the WVSMA at (304) 925-0342 by noon on January 19 to register
or
you may register at the door

Pharmaceutical directory of indigent programs published

The recently issued 1994 *Directory of Prescription Drug Indigent Programs* lists 63 separate programs by pharmaceutical companies to make prescription drugs available free of charge to physicians whose patients might not otherwise have access to necessary medicines.

The directory, which was first published by the Pharmaceutical Manufacturers Association (PMA) in 1992, lists the name of each program, the company providing it, information on how to make a request for assistance, the prescription medicines covered and basic eligibility criteria.

Healthcare professionals and patients may obtain a copy of the updated directory by writing to Directory of Pharmaceutical Indigent Programs, Pharmaceutical Manufacturers Association, 1100 15th Street, N.W., Washington, D.C. 20005.

Snowshoe site for cardiovascular conference

The Cardiovascular Conference at Snowshoe, sponsored by the American College of Cardiology, is scheduled for January 31 - February 2 at the Mountain Lodge Conference Center in Snowshoe, W.Va.

A total of 15.5 CME credits in the AMA's Category 1 is being offered.

For information contact the Registration Secretary, Extramural Programs Dept., American College of Cardiology, 9111 Old Georgetown Rd., Bethesda, MD 20814-1699; 800-257-4739 (outside the U.S. and Canada, 301-897-2695).

ACPM schedules credentialing test

The American College of Pain Medicine (ACPM) will hold its credentialing examination in pain medicine on February 21 at the Buena Vista Palace in Orlando, Fla.

The examination is offered once each year, and is open to any licensed physician who meets the eligibility requirements. More than 100 physicians have passed the ACPM examination and received a certificate designating them as specialists in the field of pain medicine and fellows of the American College of Pain Medicine.

For more information, contact the ACPM office at (708) 966-0459.

Pfizer expands efforts to dispense free medicines

Sharing the Care: A Pharmaceutical Access Program has recently been announced by Pfizer, the National Governors Association and the National Association of Community Health Centers. Through this program, Pfizer will provide its most advanced, single-source medicines to patients at community, migrant and homeless health centers in all 50 states who are at or below the poverty line and are not covered by Medicaid or any other insurance program covering pharmaceuticals.

This indigent care program is expected to provide medications for up to 1 million patients nationwide. It will initially operate at approximately 300 eligible centers that have in-house pharmacies. To determine the potential for expanding the program to all centers, demonstration projects are also being launched in centers that have other pharmacy arrangements.

For more information, contact RN Deborah Smith-Callahan at (404) 448-6666.

New publications available about ADA, lymphedema pumps

ADA and the Health Professional, a brochure which describes what health professionals need to know about the Americans with Disabilities Act, has been published by the President's Committee on Employment of People with Disabilities. This brochure includes basic technical information about the ADA, and a question and answer section covering the information most frequently sought by health professionals.

To obtain a free copy, contact Ruth E. Ross, President's Committee on Employment of People with Disabilities, 1331 F St., NW, Third Floor, Washington D.C. 20004-1107; (202) 376-6200; (202) 376-6205 (tdd); or (202) 376-6868 (fax).

Another free publication which has also been recently released is a review of lymphedema pumps printed by the Agency for Health Care Policy and Research (AHCPR).

Copies of this review are available from AHCPR Publications Clearinghouse, P.O. Box 8547, Silver Spring, MD 20907, (800) 358-9295; or from AHCPR Instant FAX (1-301-227-0800).

State ophthalmologists schedule national spring meeting

The 47th Annual National Spring Meeting of the West Virginia Academy of Ophthalmology is set for April 21-24 at The Greenbrier in White Sulphur Springs.

Featured speakers will be Marshall M. Parks, M.D., Steven A Newman, M.D., and Frank LaPiana, M.D.

For more details, contact Pam Stevens, West Virginia Academy of Ophthalmology, P. O. Box 5008, Charleston, WV 25361; (304) 343-5842 or 344-9466

Toll-free hotline answers questions about Rocephin®

Roche Laboratories, a division of Hoffmann-La Roche Inc. is operating a toll-free number (1-800-624-0264) designed to answer questions about reimbursement options for Rocephin®, an injectable antibiotic used to treat a wide variety of moderate to severe infections.

The phone line is staffed by experts on reimbursement issues and operates from 9 a.m. - 5 p.m. (EST) Monday through Friday.

Annual critical care course set for March

The 21st Annual Critical Care Medicine Course will be presented by The University of Oklahoma Health Sciences Center from March 5 - 10 at the Marriott Hotel in Oklahoma City, Okla.

CME credits offered will include AMA, AAFP, AOA, ACPE.

For more details contact: Ms. Dora Lee Smith, Course Coordinator, OHUSC Department of Medicine, P.O. Box 26901 - Room 3SP 400, Oklahoma City, OK 73190, (405) 271-5904.

The West Virginia State Medical Association & Conomikes Associates, Inc.

Present

Jan Woerth Ph.D.

MANAGED CARE
Preparing for the Clinton Health Plan

January 20, 1994

Lakeview Resort and Conference Center
Ballrooms 1+2, and lunch 3+4
Morgantown, West Virginia
9 a.m. to 4 p.m. (Lunch provided)

Workshop Outline

1. **Who are the payers**
   - Fee-for-service variations
   - Regional cooperatives and alliances
   - Large companies/self-insured
   - Medicare/Medicaid
   - HMOs, PPOs, other managed care

2. **How will you be paid**
   - Standard benefit packages
   - Co-payment increase
   - Capitation
   - Fees for global services

3. **Collection issues will differ**
   - Co-payments at time of service
   - Withhold and risk pools
   - Out-of-contract services

4. **How certification works**
   - Gatekeeper function
   - Treatment authorizations
   - Hospital authorizations
   - Referral authorizations
   - Denied authorizations

5. **How physicians may reorganize their work**
   - Money issues
   - Income distribution problems
   - Group formations
   - Scheduling issues
   - Staffing for efficiency

6. **How to look at contracts**
   - Key points to include
   - What to watch for
   - Payment issues
   - Termination clauses
   - "Hold harmless" provisions

7. **How to track your results**
   - Determining which plans are favorable and unfavorable
   - Keeping track of your plans
   - Tracking withholds and risk pool utilization

For a FREE Brochure on this seminar or to register, contact Becky Campbell at the West Virginia State Medical Association at (304) 925-0342.

Three FREE Bonuses

• Conomikes Workshop Workbook • 3-month Subscription to Conomikes Medicare Hotline • 3-Month Subscription to Conomikes Reports

Continuing Medical Education

Listed on this page are some of the upcoming CME programs which will be held in the state. Unless otherwise noted, the events are presented at the location under which they appear.

If you would like to have the CME programs offered by your institution or association for physicians printed in the *Journal* or obtain more details about the meetings listed, please contact Nancy Hill, managing editor, at 925-0342.

Robert C. Byrd Health Sciences Center of WVU - Charleston

January 20
"Teleconference on Breast Cancer 1994," Daniel Foster, M.D., Dept. of Surgery, CAMC

January 31-February 2
"Cardiovascular Conference at Snowshoe" (co-sponsored by the American College of Cardiology), Snowshoe, W.Va.

February 3
"Ovarian Cancer Screening: When Is It Helpful?" Fernando Recio, M.D., Dept. of Obstetrics and Gynecology, HSC

Robert C. Byrd Health Sciences Center of WVU - Morgantown

February 18-20
"Primary Care Perspectives on Women's Health" (sponsored by the WVU Dept. of Family Medicine), Snowshoe Resort, Snowshoe, W.Va.

March 18-19
"AIDS in West Virginia" (sponsored by the WVU Dept. of Medicine, Section of Infectious Disease), Charleston House Holiday Inn, Charleston

West Virginia State Medical Association - Charleston

January 20-23
WVSMA/WV-ACP 1994 Mid-Winter Seminars and Scientific Conferences, Lakeview Resort and Conference Center, Morgantown

Outreach Programs

Key to Sponsors

★ *Robert C. Byrd Health Sciences Center of WVU, Morgantown*

☐ *CAMC/Robert C. Byrd Health Sciences Center of WVU, Charleston*

Gassaway ☐ Braxton County Hospital, Jan. 25, 6:30 p.m., "Medical Evaluation of Sexually Abused Children," Kathleen Previll, M.D.

Logan ☐ Logan General Hospital, Jan. 21, 11:45 a.m., "Skin Cancer," Brad Cohen, M.D.

Man ☐ Man Appalachian Regional Hospital, Jan. 19, 6:30 p.m., "Preventative Screening in Oncology," Arvind Kamthan, M.D.

Oak Hill ☐ Plateau Medical Center, Jan. 25, 6:30 p.m., "Blood Transfusion," Mary Taylor, M.D.

Parkersburg ★ Camden-Clark Memorial Hospital, Jan. 26, 7 a.m., "Is There a Right to Health Care?"

★ Camden-Clark Memorial Hospital, Feb. 9, 7 a.m., "Acute Respiratory Failure"

★ Camden-Clark Memorial Hospital, Feb. 16, 7 a.m., "What's New in the Treatment of Childhood Cancer?"

★ Camden-Clark Memorial Hospital, Feb. 23, 7 a.m., "Return to Work for the Injured Worker: Principles and Caveats"

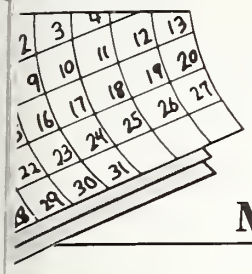
★ Camden-Clark Memorial Hospital, Mar. 16, 7 a.m., "Management of Obesity"

Philippi ★ Broaddus Hospital, Feb. 3, 7 p.m., "Scoliosis/Spinal Deformity" (Pediatrics)

★ Broaddus Hospital, Mar. 3, 7 p.m., "AIDS"

Point Pleasant ☐ Pleasant Valley Hospital, Jan. 27, noon, TBA, Constantino Y. Amores, M.D.

Williamson ☐ Williamson Appalachian Regional Hospital, Jan. 27, 6:30 p.m., "Abdominal Trauma," Bruce Hoak, M.D.



Medical Meetings

January

20-22–28th Annual Meeting of the Neurosurgical Society of the Virginias, White Sulphur Springs, W.Va.
20-23–WVSMA/WVACP 1994 Mid-Winter Seminars and Scientific Conferences, Morgantown
27-29–13th Annual Big Sky Pulmonary Ski Conference (sponsored by American Lung Association of Montana), Helena, Mont.
27-30–20th Annual Postdoctural Education Conference (sponsored by the Society of Teachers and Family Medicine), Tucson, Ariz.
27-Feb.1–American Academy of Otolaryngic Allergy, Tampa, Fla.
28-29–Transfusion Medicine: Update 1994 (sponsored by the American Association of Blood Banks), Seattle, Wash.
30-Feb. 4–Westwood Winter Skin Seminar, (sponsored by Westwood - Squibb Pharmaceuticals), Vail, Colo.
31-Feb. 2–Cardiovascular Conference at Snowshoe (sponsored by the American College of Cardiology), Snowshoe, W.Va.

February

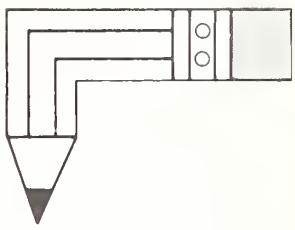
1-5–19th Annual Meeting of the Alliance for CME (sponsored by the George Washington University Medical Center), San Diego, Calif.
6-10–Southeastern Surgical Congress, Lake Buena Vista, Fla.
11-12–Topics in Radiology (sponsored by the University of Pittsburgh Medical Center), Pittsburgh, Pa.
12–Infectious Diseases (sponsored by Ohio State University), Columbus
18-20–1994 Annual Refresher Course and Conference of the American Academy of Pain Medicine, Orlando, Fla.
20-23–First International Symposium on the Role of Soy in Preventing and Treating Chronic Disease, Mesa, Ariz.
24-Mar. 1–American Academy of Orthopaedic Surgeons, New Orleans, La.
26-Mar. 5–Topics in Gastroenterology and Internal Medicine (sponsored by the George Washington University Medical Center), Barbados
28-Mar. 3–The Alton D. Brashear Postgraduate Course in Head and Neck Anatomy, Medical College of Virginia, Virginia Commonwealth University, Richmond, Va.

March

4-5–The 37th Annual Postgraduate Symposium in Ophthalmology: Diagnostic Pathology (sponsored by Ohio State University), Columbus

For More Information . . .

Contact the Journal at (304) 925-0342.



Poetry Corner

Group Therapy

Voices
(In the New Choir)
Unify in a grotesque cacophonous minuet
(Achapella)
Whose dissonance clangs on its own off-step noisy
Parody

Chorally
or in
Sanctioned Solo
They annotate
The threnody and lost harmony
Of individual or collective lives

The choirmaster neither directs nor sings
Yet his sonorous queries evoke a rhythm
A thin melodic line transcends the clatter
Atonality yields to hesitant richness
A refrain reverberates each time the voices sing
From fugue to resonant sinfonia

The choir is an instrument
Playing triumphantly to those in tune
Blaringly to those off-key
It is destroyed after each use
Recreated, never seems the same
Although it works the same.

Through intricate practice sessions
Symbolic serendipides
The choir
Learns words
Of songs that write themselves
To music with no score

Ralph S. Smith Jr., M.D.

Please address your submissions for Poetry Corner to Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

Department of Health & Human Resources

Bureau of Public Health News

This page of material is submitted and paid for by the Bureau of Public Health.

MMWR highlights smoking concerns

The November 12 issue of the Centers for Disease Control's Morbidity and Mortality Weekly Report featured several important articles on smoking and health risks.

The report said that more physicians and their organized medical groups are, and should be, becoming leaders in nationwide efforts to stop smoking since their counseling efforts can be a very valuable tool. The report detailed the effectiveness of these counseling efforts in 1991 in a report to the National Review Interview Survey (Health Promotion and Disease Prevention supplement.) Cigarette smoking remains the single most preventable cause of premature death in the United States.

The November 12 issue of the MMWR also contained a report on mortality trends for selected smoking-related cancers and breast cancer in the United States for the years 1950-1990. During 1990, nearly 419,000 deaths, or approximately 20% of all U.S. deaths, were attributed to smoking. This included more than 150,000 deaths from neoplasms. The report related that the public health burden of smoking-related cancers will continue throughout the next several decades. It also examined the trends of mortality for cancers that are significantly related to smoking and compares lung cancer mortality with breast cancer mortality, which has not been linked to smoking.

For a copy of the November 12 MMWR or for more information on smoking-related health concerns, contact Joyce Edwards of the Bureau of Public Health's Tobacco Control Program at (304) 558-0644.

Canaan Valley site for rural health workshop

Health care providers from around the state will meet in Canaan Valley on February 21 and 22 for a workshop entitled "Developing a Rural Primary Care Network: A Hands-On Approach."

Sponsored by several health care organizations, the workshop will focus on the challenges and opportunities for communities under new health care reform proposals, and will offer federal and state government resources to help communities organize health care networks to maximize their resources in delivering health care.

For more details about the workshop or rural health care networks, call the Bureau's Office of Rural Health Policy at (304) 558-1327.

Two West Virginia hospitals lead the way in new program

Broaddus Hospital in Philippi and Webster County Memorial Hospital in Webster Springs have recently been designated the state's first and second Rural Primary Care Hospitals, or RPCH's (rhymes with peach) and only the second and third such facilities in the nation.

The designations come as part of the Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) Program, designed to improve the health care services of rural communities by maximizing available resources and reducing duplicate services. Small, rural acute care hospitals, such as Broaddus and Webster, are converted to RPCHs and linked with larger acute care hospitals known as EACHs. Broaddus Hospital will join forces with Davis Memorial Hospital in Elkins, while Webster Memorial will become a partner with United Hospital Center in Clarksburg.

The process calls for the smaller hospitals to change the way they provide health care services, by reducing their acute-care bed capacity to no more than 12 beds. These facilities also eliminate inpatient surgical services and keep patients no longer than 72 hours. Patients who need acute care services are referred to the EACHs. RPCHs maintain emergency medical services and other outpatient services that compliment those already in the community. By reducing competitive and costly acute care services, smaller hospitals can concentrate on enhancing primary care and emergency services to better meet the immediate needs of their communities.

For more details concerning the EACH/RPCH Program, contact the Bureau's Office of Rural Health Policy at (304) 558-1327.

Immunization data system planned

The Bureau of Public Health's Immunization Program is conducting a needs analysis that will help in the planning of a Statewide Immunization Information System (SIIS).

As part of the needs analysis process, a survey of health care providers was conducted in December to measure their current computer capacity. The positive response of the medical community to this survey was critical in generating an accurate picture of the private sector.

When the SIIS is established, it will serve as a depository of immunization information for children born in West Virginia. The concept behind the SIIS will enable health care providers to have immediate access to children's immunization histories at the time of their visit for health care services. This ensures that all providers have accurate and current immunization information which will save staff both time and resources.

The support of the medical community in the implementation of the SIIS will be greatly appreciated. All health care providers will reap immediate and future benefits from the project.

If you have any questions about the planning for the SIIS, contact the Bureau's Immunization Program at (304) 558-2188 or (800)-642-3634.

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Compiled from material furnished by the Robert C. Byrd Health Sciences Center of West Virginia University, Communications Office, Morgantown.

Randolph County boy gets heart checked via MDTV from Congress

Neal

On November 5, Dr. William Neal, a children's heart specialist who chairs the Department of Pediatrics, checked in on one of his rural patients via MDTV from a Senate office building in Washington, D.C.

The exam was part of a telemedicine demonstration organized by Senator Jay Rockefeller to show the applications of technology in improving health care around the world. The patient, 15-month-old Jeremy Liggett of Mill Creek in Randolph County, shared the spotlight with a three-year-old in Moscow who has a tumor. The Russian child was examined over a satellite link provided by NASA. The entire event was telecast worldwide via satellite.

D'Alessandri receives ACMGA award, named to lead reform project

D'Alessandri

Dr. Robert D'Alessandri, vice president for health sciences and dean of the School of Medicine, was recently presented with the 1993 Medical Executive Award of the American College of Medical Group Administrators. The annual award is given to one physician in the United States who exemplifies leadership in the field of medical group practice.

Dr. D'Alessandri also has been named chair of the West Virginia Health Care Reform Project (WVHCRP). Dr. Robert Walker, professor and chair of family and community health at Marshall University, will be vice-chair. The appointments were announced by Senator Jay Rockefeller, who created the WVHCRP to involve a wide spectrum of West Virginians in the creation of state and national comprehensive health care reform.

WVU cardiologists perform first stent device procedure

Maxwell

Jain

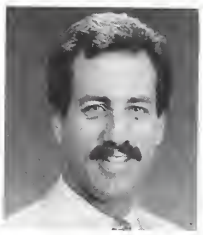
A man with a long history of heart disease underwent the first coronary procedure using a stent device at WVU Hospitals on November 15. The procedure was performed by Dr. Abnash C. Jain, professor of cardiology, and Dr. Leeman P. Maxwell, associate professor of cardiology.

"This man was over 60 years old and had bypass surgery in the past, as well as two balloon angioplasties," Dr. Jain said. "The new procedure was used to keep the artery open. The stent device, which is a stainless steel coil, was placed in the lining of the artery to keep the walls from collapsing."

"The balloon inflates and the coil is pressed outward into the artery," Dr. Maxwell further explained. "It's designed so that, once it's expanded, radial force is exerted allowing the blood to flow. This decreases the risk of a heart attack or the need for emergency bypass surgery."

The stent becomes a permanent part of the artery, and because it is stainless steel, the stent is not rejected by the body.

Cancer Center using new drug for patients


Korb

Metastron, a drug approved in June by the F.D.A. is being used to treat patients with painful cancer metastases of the bones at the Mary Babb Randolph Cancer Center.

"Metastron, a radioactive form of Strontium-89, is a compound similar to calcium," says Dr. Leroy Korb, associate professor and section chief of radiation oncology. "It's uptaken by bone in the body, where it delivers a very precise dose of intense radiation to the sites of cancer metastases. The best responses are in people who have metastases from either breast or prostate cancer."

Metastron is so specific "its uptake is either in the bone or it's excreted by the body," Dr. Korb explained. "Therefore, the other organ systems of the body — such as the bone marrow, the liver and the heart — all receive very low doses of radiation. "It has very low toxicity. Side effects are almost nil, and there are very few contraindications to its use."

Cancer program granted ASC approval

The American College of Surgeons has granted a three-year approval to the cancer program at WVU Hospitals.

In his letter announcing the committee's approval, David P. Winchester, M.D., F.A.C.S., medical director of the Cancer Department, wrote that "all elements appear to be in place and functioning to provide educational, multidisciplinary exchange on cancer patient management, to encourage quality control and audits, and to monitor the success of primary and secondary treatment through long-term follow-up."

Dr. Mark Wax is chair of the WVUH cancer committee.

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Marshall University School of Medicine

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington.

Plans underway for Center for Applied Biotechnology

The Marshall University Foundation has acquired the former Butler Furniture Co. building at 434 20th St. to house a proposed Marshall University Center for Applied Biotechnology.

MU President J. Wade Gilley said the university is retaining an architectural/engineering firm to perform programming studies and provide renovation cost estimates. The university is also seeking grants through the National Institutes of Health and the National Science Foundation to cover renovation costs for the building, which contains 18,900 square feet.

The Center for Applied Biotechnology is being developed in three phases by the School of Medicine under the direction of Dr. L. Howard Aulick, assistant dean for research development. Phase 1 will be the forensic science division, featuring a state-of-the-art DNA typing facility. This will consist of a cell molecular biology laboratory designed to support the accelerating demands for identity testing by law enforcement agencies and the courts. It also will serve as a training center for a molecular-based master's degree in forensic science.

Phase 2, the medical sciences division, will be developed through creation of an advanced medical diagnostics laboratory as an extension of the DNA typing facility. It will provide both DNA-based and non-DNA-based clinical diagnostics, emphasizing assays for cancer, infectious diseases and genetic diseases. Under the proposal, it will feature only those educational, research and clinical services not available at existing local medical facilities.

Phase 3, the environmental science division, will focus on the research of investigators in the College of Science and the School of Medicine concerning environmental effects with the long-term goals of environmental reclamation and restoration of health.

Dr. Terry W. Fenger, acting chairman of Marshall's Department of Microbiology, Immunology and Molecular Genetics, told Marshall's Faculty Senate he hopes to have the forensic science division, including the master's degree program, initiated by fall 1995. The Phase 1 proposal has been approved by the Faculty Senate and by Gilley. It will be submitted to the University of West Virginia Board of Trustees for final approval.

"These are the types of programs that will put Marshall in the forefront of scientific research, education and application in the years ahead," Gilley said. "Even more importantly, they will prepare students for the kinds of jobs our region will need to prosper in the future."

Cabell Huntington proceeds with plans for outpatient center

Cabell Huntington Hospital in late December took the next step toward a new outpatient center for the Marshall University School of Medicine by submitting a letter of intent to the West Virginia Health Care Cost Review Authority (HCCRA).

The hospital's Certificate of Need application was expected to be filed in time for the upcoming HCCRA review cycle. HCCRA ruled last month that the original letter of intent, submitted early in the planning process, needed to be updated. The new letter describes associated projects, such as Marshall's federally-funded Center for Rural Health, that were not known when the original letter was filed.

The new letter also includes, at HCCRA's request, information on future projects that could or would result from developing the complex. The document proposes construction of a complex that includes the outpatient care center, Marshall's Center for Rural Health, and academic and administrative space.

The four-story outpatient center will provide patient care areas and faculty offices for the school's departments of Family and Community Health, Medicine, Obstetrics/Gynecology, Pediatrics and Surgery. The Center for Rural Health, located next to the outpatient center, will serve as the hub of the school's rural medicine activities. The academic health space, which will be added if private fund-raising is successful, will provide support space for the Department of Psychiatry and administrative offices for the School of Medicine.

In addition to the medical center complex, the project plan includes a connector to link it to the hospital. The connector would tie in with a new main entrance and lobby for the hospital, as well as with a reconfiguration of the patient registration area. Cabell Huntington Hospital will pay the estimated $3.9 million to make these changes.

Nurse practitioner program granted initial accreditation

The master of science in nursing — family nurse practitioner program has received initial accreditation from the National League for Nursing, School of Nursing Dean Lynne B. Welch has announced.

The accreditation is retroactive to 1992. The league scheduled a site visit for reaccreditation in spring 1998.

The Marshall program, developed in response to West Virginia's need for qualified mid-level health professionals, graduated its first class in 1992. West Virginia students in the program have come from Raleigh, Logan, Wayne, Kanawha, Cabell, Lincoln, Putnam and Wood counties. Participants have done most of their clinics in underserved areas of Boone, Jackson, Wayne, Cabell, Kanawha, Putnam and Lincoln counties.

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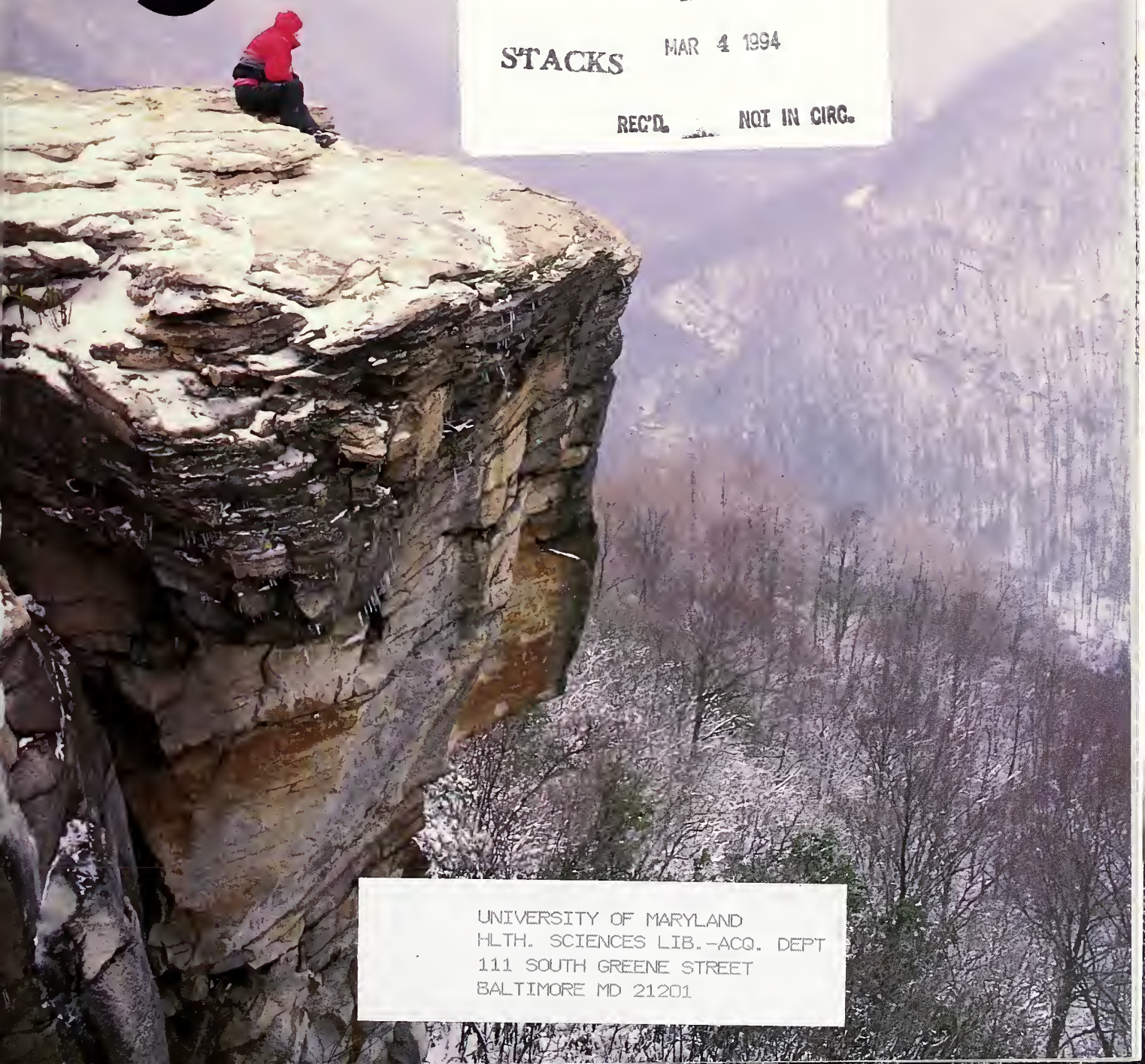

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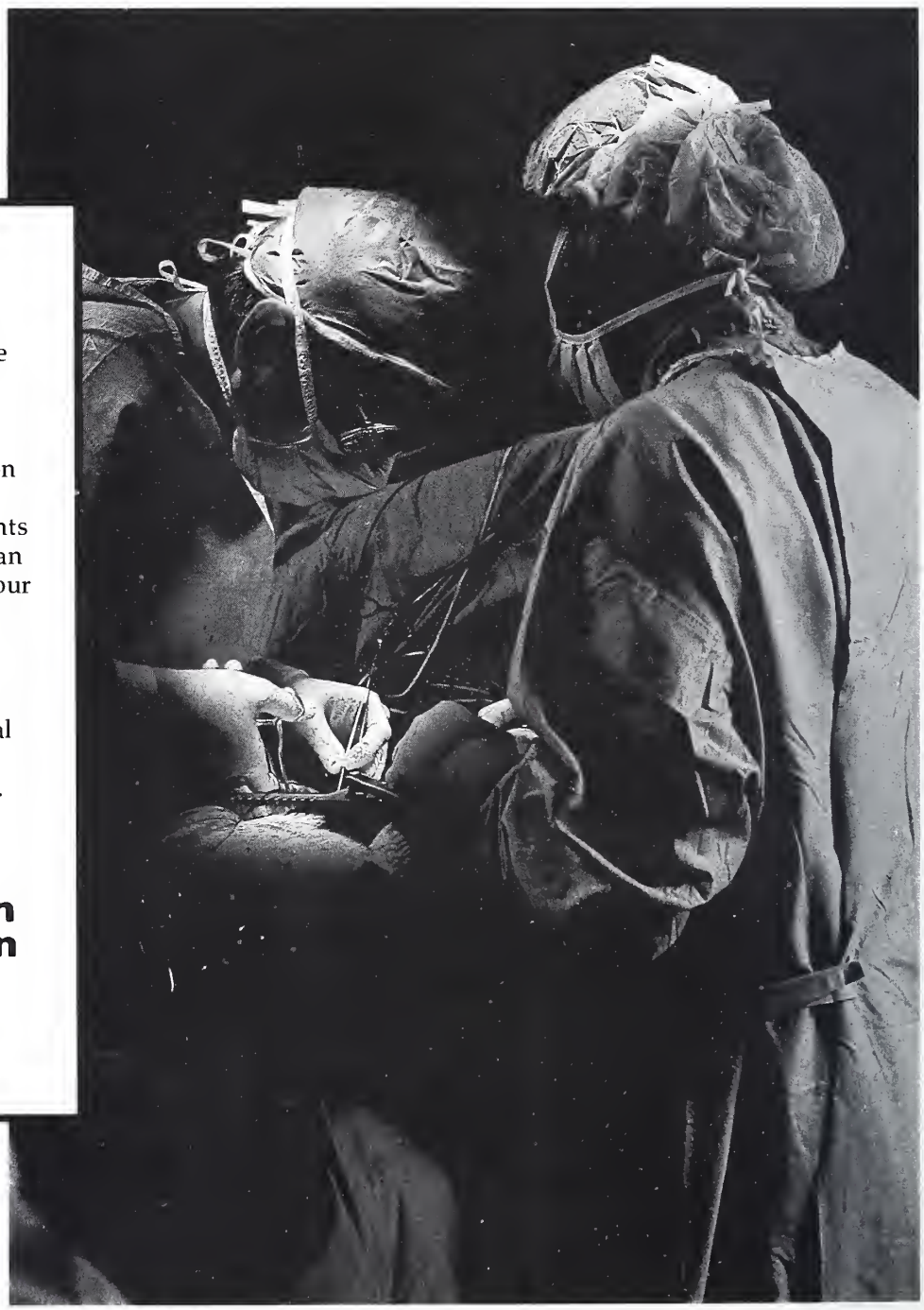

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Front Cover

A hiker views a wintry scene on Lindy Run Overlook at Blackwater Canyon in Tucker County. Photo courtesy of *Stephen J. Shaluta Jr.,* West Virginia Division of Tourism and Parks.

Employment, race and poverty in West Virginia: Implications for practicing physicians

ROBERT M. FRUMKIN, Ph.D., F.A.A.A.S.
Associate Professor, Humanities and Social Sciences Department, Salem-Teikyo University, Salem, W.Va.

Abstract

Since West Virginia became a state in 1863 and slavery was abolished, poverty has been a persistent problem for black Americans. Although blacks have become increasingly a part of the total workforce, moving from the lowest level, lowest paid jobs to higher level, better paying ones, unemployment, poverty, and their common sequelae still persist and significantly differentiate black from white Americans. While racial discrimination has been a factor in black poverty for many decades, another critical factor responsible for black poverty today and in the past, is something which both blacks and physicians can help to change -- unplanned parenthood.

Introduction

Since World War II, physicians have become increasingly aware of the fact that race is a critical factor in the health of the communities and the patients which they are called upon to serve (1). To be black in America means, in health and social terms, to be subject to significant differential categoric risks for unemployment, mental disorders, various medical disorders (other than mental), drug abuse, crime, poverty, and a host of other unfavorable conditions (2).

While living conditions for blacks nationally have been relatively poorer than for whites, it is known that individual states vary much in terms of the actual conditions and problems experienced by blacks. For example, Ohio, as compared to New York, has had significantly more black unemployment with all its dire consequences (2). This article is designed to evaluate the living conditions of blacks in West Virginia and examine the implications for practicing physicians.

Historical background

During the great Civil War, the western countries of Virginia, which favored the abolition of slavery, broke away from the rest of the state and formed the new state of West Virginia (June 20, 1863). The new state formed its own government and was loyal to the Union forces. Even though West Virginia was loyal to the Union, that did not mean that there did not exist bigotry towards blacks. But, West Virginia, on the whole, seemed to be relatively free of the virulent kind of racism rampant in other parts of the United States.

The desire of the western counties of Virginia to form an independent government was not new in 1863. As early as 1776, these citizens petitioned for their own government. Whereas, the eastern counties of Virginia had an aristocratic lifestyle, based mostly on wealthy tobacco plantations, the western counties had a hardworking, frontier lifestyle which consisted mainly of farming and raising livestock.

One big disagreement between the western and eastern sections concerned the tax break easterners received for owning slaves. First, black slaves under 12 years of age were exempt from taxation and the slaves that were older could not be assessed in excess of $300. The easterners got the best transportation breaks, such as an adequate system of railroads, while the western counties always seemed to get second-class state allocations because the aristocratic eastern counties controlled the state. Thus, contrary to popular current opinion, the matter of slavery was not, per se, the central issue between the eastern and western counties. It was rather the differential control of power and all its many practical consequences (3).

To understand the status of blacks in America society today, it is imperative to examine the history of blacks in the American slave economy and their experiences following the Civil War and the Emancipation Proclamation. At the time of slavery, except for free blacks, all blacks were part of southern agriculture or were household servants. As late as 1900, this was a fact for 87 percent and even in 1910, it was 80 percent. However, by 1960 less than 10 percent of blacks were employed in agriculture and 15 percent in domestic service positions. In fact, by 1960, about 10 percent were employed in professional and semi-professional occupations.

The movement for blacks, from agricultural to non-agricultural work, seems to have been influenced by these five factors:

1. Job competition between blacks and whites, especially southern whites and European immigrants.
2. Handicaps blacks have had because of their slave origins, i.e. undeveloped skills, poor education, etc.
3. Black progress in jobs has been related to periods of great labor demand and low rates of unemployment. Most jobs for blacks were low-paying ones which whites did not want.
4. The greatest opportunities have been in expanding industries during rapid growth, but not in stable or declining industries.
5. Most progress made by blacks has been made in areas such as education and public health where government was heavily involved. Military service has also been very popular, and black employment in government agencies has been substantial.

The changing nature of black employment in the United States since the Civil War is a fascinating topic much too complex to deal with in this short paper (4). In spite of everything, blacks have managed to expand their job alternatives, but, in our depressed economy, the maintenance of job

stability has been a persistent problem.

Race and poverty in West Virginia

Prior to the 1970 U.S. Census, poverty statistics were not published. What we do have for previous years is a reasonable substitute for such statistics when we examine family income. For example, in 1959 in West Virginia, the median income for all families was $4,572. For non-white families (virtually all black) it was $2,874. Non-white family income was 63 percent of white family income. At that time, with no poverty status guides firmly set, it was felt that an annual income between $2,000 and $4,000 meant that such families were growing up "under adverse economic circumstances" (5).

The 1970, 1980 and 1990 U.S. Censuses have provided definitive data as shown in Table 1. For West Virginia, we may now compare white and black poverty levels for those periods. Table 1 shows that if we define poor as being a member of a family whose income is less than the poverty level established by the U.S. Census, then, for the past two decades, blacks in West Virginia have been almost twice as poor as whites.

Employment and unemployment

There are two aspects important to the issue of employment. First, there is the matter of being employed or not being employed. Having a job, not being unemployed is critical. Second, there is the question of the type of employment, that is, is it a position requiring just a few skills which is long on hours and short on wages, or is it a skilled job which pays a wage which can help sustain a decent standard of living?

When blacks left farming and domestic service jobs to seek a better way of life, most obtained mainly low-paying jobs requiring minimal skills because they were so poorly educated. As the levels of education of blacks have increased and higher level, higher-paying jobs have become available, the picture of the employment demographics for blacks has changed significantly. Table 2 shows how dramatically the occupations of blacks in West Virginia changed from 1960 as compared to 1980.

But how do blacks compare with whites in West Virginia with respect to unemployment? During the war on poverty and the Vietnam War, unemployment rates for whites and blacks were relatively low. However, in 1980 and 1990, unemployment was significantly higher for blacks compared to whites.

Table 3 presents us with the national unemployment picture and Table 4 provides details on unemployment in West Virginia. Examination of these two tables show us that nationally, unemployment for blacks is more than twice that of whites. However, in West Virginia, the unemployment rates have been better than the national picture, yet, by 1990, were still approaching a rate twice as great as the unemployment rates for whites. Numerous studies of unemployment provide us with evidence that serious health and social problems are associated with high rates of unemployment (6,7).

In West Virginia in 1989, the mean household income for white families was $27,226, but $18,904 for black families. For 1989, a family of four persons with an annual income of

TABLE 1. Poverty Status of West Virginia Families by Race in 1969, 1979 and 1989 (Percent Income Less Than Poverty Line)

Year	White	Black	Ratio
1989	19.1%	36.0%	1.9%
1979	11.4%	21.4%	1.9%
1969	17.5%	31.9%	1.8%

TABLE 2. Occupations of Blacks in 1960 and 1980 in West Virginia

Occupation	1960	1980	Percent Change
Professional, Technical	7.3%	10.5%	+3.2%
Managerial	1.6%	5.5%	+3.9%
Clerical, Sales	4.6%	25.7%	+21.1%
Service	42.0%	26.3%	-15.7%
Skilled	4.9%	11.2%	+6.3%
Semi-skilled & Unskilled	38.0%	19.3%	-18.7%
Farming	1.6%	1.5%	-0.1%
	100.0%	100.0%	

TABLE 3. Unemployment for Blacks and Whites in the U.S. in 1970, 1980 and 1990

	1970	1980	1990
Total	4.9%	7.1%	5.5%
Male	4.4%	6.9%	5.6%
Female	5.9%	7.4%	5.4%
Race			
Whites	*	6.3%	4.7%
Blacks	*	14.3%	11.3%
White\Black Ratio	*	2.3%	2.4%

*No white\black data for the 1970 census.

TABLE 4. Unemployment for Blacks and Whites in West Virginia in 1970, 1980 and 1990

	1970	1980	1990
Whites			
Total	5.1%	8.3%	9.4%
Male	4.9%	9.1%	10.1%
Female	5.4%	7.1%	8.4%
Blacks			
Total	7.0%	12.3%	17.3%
Male	6.6%	14.3%	18.4%
Female	7.6%	10.1%	16.2%
White\Black Ratios			
Total	1.4%	1.5%	1.8%
Male	1.3%	1.6%	1.8%
Female	1.4%	1.4%	1.9%

TABLE 5. Size and Race of Families in the U.S. Below Poverty Level in 1989

	Percent Below Poverty Level		
	All Races	White	Black
Total	10.3%	7.8%	27.8%
Size of Family			
Two Persons	8.2%	6.6%	22.7%
Three Persons	9.8%	7.1%	27.3%
Four Persons	10.1%	8.0%	25.8%
Five Persons	13.5%	10.3%	33.2%
Six Persons	21.1%	15.6%	44.3%
Seven Persons	32.3%	25.5%	51.2%

Source: U.S. Bureau of the Census, Current Population Reports, Series P-60, No. 168, 1991.

$12,674 or less was considered as living below the poverty level. Using that definition, 19.1 percent of whites and 36.0 percent of blacks in West Virginia lived in poor families. Thus, the ratio of black families in poverty as compared to whites was approximately double.

Implications for practicing physicians

Although blacks in West Virginia have shown significant gains in moving from less skilled jobs to higher level occupations (Table 2), the ratio of black to white families living in poverty is approximately double (Table 1). Nationally, blacks have experienced more than two times the unemployment rates for whites (Table 3).

While unemployment rates for blacks in West Virginia has been significantly less than the national rate, it is still almost twice that for whites (Table 4). The question remains as to why, with the increase of blacks in higher level occupations, is there still so much poverty among blacks as compared to whites?

When Dr. Jocelyn Elders recently became the U.S. Surgeon General, in her acceptance speech, she hinted as to how any family can reduce their risk for poverty and the ill health which often becomes its partner. She simply said that planned parenthood must be central to any national health plan because unplanned families are a major source of poverty and ill health. While we have, as yet, no state figures on the relationship of poverty to family size, it has been shown nationally that there is almost a geometric increase in poverty with the increase in family size and that among blacks, as compared to whites, large, presumably unplanned families are factors in this relationship (Table 5). This philosophy is also described by sociologist Dr. Clifford Kirkpatrick in his book "The Family," when he states "The economic implications of differential fertility have the utmost significance. A group which because of race cannot control job supply may thrive or suffer, depending on fertility" (8).

If West Virginia and the United States is to have a successful national health plan, then physicians must become advocates for planned parenthood in both their practice of medicine and as responsible public citizens. When anti-abortionists are critical of physicians supporting planned parenthood, physicians must respond to such challenges by pointing out that they are not so much pro-abortion as much as they are against unplanned pregnancies which often lead to multiple health and social problems. They must emphasize, as Dr. Elders has, that abortions are generally necessary only when people have irresponsible sex relations, when they permit unplanned pregnancies to take place.

A successful national health plan is inconceivable without planned parenthood. The poverty of blacks as compared to whites, nationally and in West Virginia, is related in a significant degree to unplanned parenthood and its many correlates. Examination of Table 5 shows the national picture in a dramatic way and I feel every practicing physician has a vital role in the success of any national health plan and the West Virginia health plan.

Acknowledgments

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Increasing screenings for breast and cervical cancer in West Virginia

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Introduction

There is, by now, no doubt that Pap smears have been effective in reducing the frequency of invasive cancer of the cervix and the number of deaths that result from this condition. The challenge continues though for physicians to encourage all of their female patients to have Pap smears, especially women who are at higher risk of developing cervical cancer. Of the 40 to 50 West Virginia women who die of cervical cancer each year, almost all of them have not have a Pap smear for at least three years.

There is also the expectation that the use of mammography will, in due course, reduce mortality from breast cancer. Certainly, the tumors can be found at an earlier stage and less mutilating operations are possible, but again, the challenge is to get women to receive the test.

The most convenient and cost-effective way that women can obtain both a Pap smear as well as have a mammogram performed, is for both of these tests to be offered to them when they visit their primary care physician. To study the procedures of primary care physicians in West Virginia in regards to Pap smears and mammograms, a questionnaire was mailed randomly in late spring of 1992 to 440 family or general practitioners, general internists and ob/gyns.

Methods

A total of 440 West Virginia family or general practitioners, general internists, and ob/gyns were randomly selected from the M.D. licensure rolls and mailed a questionnaire in late spring 1992. This represented about one fourth of the entire licensure list in these categories. The questionnaire asked about office practice procedures and characteristics, referral patterns, and continuing medical education topic choices.

One week after the questionnaire had been mailed, a postcard was sent to these same physicians to thank those that had responded and encourage those that had not answered the questionnaire to still respond. In addition, a second copy of the questionnaire was mailed to those who did not respond three weeks after the initial mailing, and another follow-up reminder was conducted by phone three weeks later.

Out of the original sample of 440 physicians, it was discovered that 16 had retired, 22 were practicing specialties not related to the questionnaire, 11 had relocated, and two had died. This now brought the total number of physicians in the sample to 389, and of this number, 178 completed the questionnaire for a total response rate of 46%.

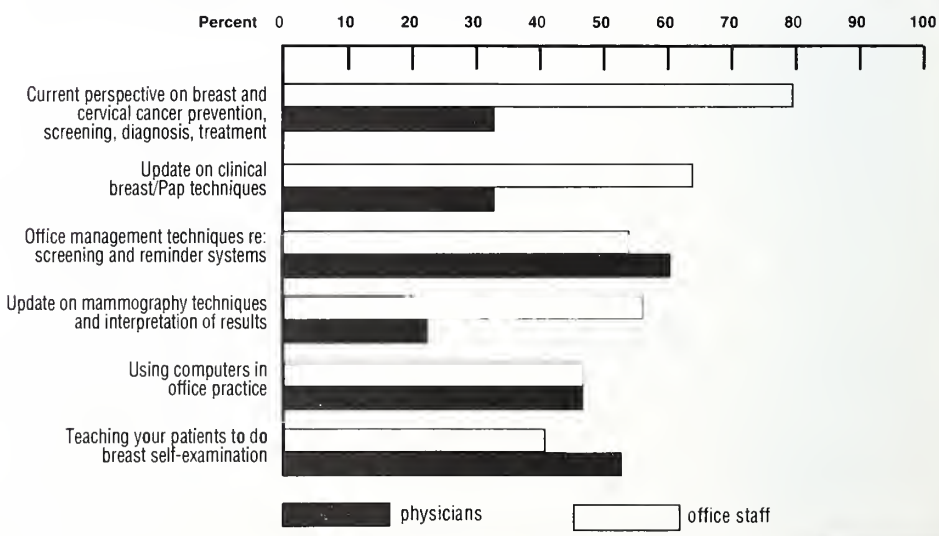
Findings

The questionnaire revealed that most physicians do screen in their office practices for both Pap smears (92%) and clinical breast examinations (97%). In addition, 23% perform colposcopies, 22% cauterize cervixes, 15% perform conizations, and 10% perform needle biopsies of the breast.

In terms of seeing whether individual patients making an office visit are up-to-date with their screening, 28% have their office staff flag the chart, 8% have a computer printout, and 10% do not have a particular method. Most (85%) rely upon their own review of the chart to see whether screening is indicated.

The study discovered that 74% of these physicians responding had no procedure for contacting female patients at home to remind them to have Pap smears and mammograms, that one in five (19%) rely on manual chart reviews to find the women who need screenings, and that only 6% have help from a computer.

FIGURE 1
WHAT CME THE PHYSICIANS SURVEYED WANT FOR THEMSELVES AND THEIR STAFFS



When an abnormal finding is reported on the smear or mammogram, 87% of the physicians questioned contact these patients by mail or phone. However, the remaining 13% said they waited for the women to take the initiative.

The questionnaire also provided valuable insights into what types of continuing education could benefit these physicians and their staffs (Figure 1). The physicians expressed at least a 40% interest in programs relating to office management skills, use of computers in clinical practice, and teaching patients breast self-examination for both themselves and their staff. In addition, at least 50% of the physicians wanted CME on current perspectives on screening, techniques of screening, and mammography interpretation.

Discussion

Pap smears and mammograms are two screening activities which are slowly being included in the regular office practice of medicine. It is obvious, though, that there is a lack of office procedures that make the need for screening automatically detected without too much effort on the part of physicians and their staffs.

Fewer than half of the primary care physicians questioned utilized a computer, "tickler file," or colorcoding of patient record folders to alert themselves to the fact that it was time for one or both of these screenings for their patients. In addition, the study revealed that a small portion of physicians do not even notify patients of an abnormal finding on Pap smears or mammograms. This is a critical situation that needs attention.

The challenge now is to develop materials that will facilitate the incorporation of these screening procedures into regular office practice. Simple reminder systems, both manual and computerized, that can trigger letters to patients reminding them that they are due for exams need to be made available to practices that would like to use them. CME programs can include these systems to maximize dissemination and give instructions on their use.

One important way that brochures and CME programs regarding breast and cervical cancer screenings is being distributed is through the Breast and Cervical Screening Program, a CDC-funded program of the West Virginia State Bureau of Public Health, provided by the Mary Babb Randolph Cancer Center at the Robert C. Byrd Health Sciences Center of West Virginia University. Sample materials and information can be obtained by calling the Cancer Information Service at 1-800-4-CANCER.

A computerized screening and tracking tool that will work effectively on any PC compatible 286, 386 or 486 system, as well as generate letters, is available free of charge from the Office of Health Services Research, Robert C. Byrd Health Sciences Center of West Virginia University, Morgantown, WV 26505-9350; (304) 293-2370.

Acknowledgement

The authors wish to thank the West Virginia Bureau of Public Health and the Centers for Disease Control for funding this study.

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William Cleveland, MD
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An overview of the AMA Interim Meeting

Members of the WVSMA's delegation at the AMA Interim Meeting included Dr. John Markey; WVSMA President-Elect Dr. Dennis Burton; WVSMA Senior Councilor at Large Dr. Constantino Amores; WVSMA Council Chairman Dr. Robert Pulliam; WVSMA Associate Executive Director Nancie Divvens; Dr. Stephen Thilen; Dr. David Avery; Dr. Stephen Sebert; WVSMA Vice President Dr. James Helsley; and Dr. Robert Hess.

The 1993 Interim Meeting of the AMA House of Delegates was held in New Orleans from December 5-8. A total of 193 resolutions and 101 reports were debated and discussed at length at this meeting, with the major issue being the AMA's stand on health system reform.

I served on Reference Committee D which was involved with the issue of public health. To help the AMA leadership address the issue of health care reform, the House adopted these guidelines after hearing testimony from numerous physicians:

1. The AMA reaffirms its support for universal coverage and access to health care services.
2. The AMA supports the right for an individual to select his or her own health care plan.
3. The AMA recognizes an individual's health insurance as an alternative to employer-financed health care.
4. The AMA recognizes the needs of small businesses and the self-employed.
5. The AMA endorses and promotes health care savings accounts as an option to assure patients freedom of choice.
6. The AMA voted not to limit itself to a mandated employer health care benefit system under health care system reform. This brought the most press of any of the issues. It was not a retraction of prior commitments to mandated employer health benefits, but a request that other policies be offered. The health care benefits were to either be purchased by the vendors themselves, or by employers. Some people took this view as a means of backing away from the government's proposal, but I believe in reality it was a measure to allow other options in health care reform to be presented.
7. The AMA agrees to continue to work diligently to ensure any health reform that was passed encompass and limit all federal, state, and local employees to the same degree as the general population; in other words to make them live under the same insurance and rules that are proposed for everyone else.

The bottom line was that the House of Delegates voted to only support health care system reforms that:

1) Included universal access;
2) Did not feature rationing of care;
3) Included reasonable basic benefits;
4) That were not biased towards managed care, and
5) Included a true fee-for-service option with balance billing.

In addition, the members of the House of Delegates stated that any health care reform plan must preserve a high quality of patient care; provide meaningful antitrust relief, including the ability of state and county associations to form partnerships; provide true tort reform; provide significant insurance market reforms, and to recognize physicians' responsibility and authority in making decisions regarding medical issues.

A resolution was passed calling for continued AMA opposition to the national health board that is currently being proposed by the Clinton administration and supporting the creation of a national health advisory body that will form a private partnership to recommend health policy. Another goal discussed by the House members was to make sure that physicians were not excluded inappropriately by different managed care organizations by requiring managed care organizations and third-party payors to disclose the criteria used to select and retain physicians. Members also felt that physicians participating in these plans must be able to treat and take care of patients without the threat of punitive action.

Regarding professional liability reform, the AMA is again pushing for a $250,000 ceiling on non-economic damages; the collateral source rule and decreasing incremental or sliding scale contingency fees; periodic payments for future awards; and a limitation of the statute of limitations to no more than six years after birth. House members were also asking for federal reform to require a certificate of merit before filing a medical liability case; for statutory criteria to outline expert witness qualifications; and for demonstration projects to be set-up as alternate dispute resolution mechanisms.

The House of Delegates passed resolutions asking for regulations regarding firearm control. These included mandatory destruction of any weapons in buy-back programs and supporting legislation to outlaw Black Talon or similarly constructed bullets. This resolution also reaffirmed a current AMA policy supporting waiting periods and background checks for purchases of firearms.

The House members also adopted a very strong resolution condemning the practice of providing economic incentives to pharmacists in exchange for persuading physicians to therapeutic interchange. They also reaffirmed the AMA's opposition to payment to physicians in response for prescribing practices and stated that they consider it inappropriate for payment of any economic incentives for the purpose of influencing decisions.

In addition to this overall report on the meeting and Reference Committee D on Public Health, the other members of the WVSMA delegation also served on committees, and they have prepared reports which are available at the WVSMA office. These delegates and the names of their committees are as follows:

Reference Committee on Amendments to Constitution and Bylaws	**Dr. Comerci**
Reference Committee A ***(Medical Service)***	**Dr. Thilen**
Reference Committee B ***(Legislation)***	**Dr. Markey**
Reference Committee C ***(Medical Education)***	**Dr. Sebert**
Reference Committee E ***(Science and Technology)***	**Dr. Helsley**
Reference Committee F ***(Board of Trustees)***	**Dr. Amores**
Reference Committee G ***(Medical Practice/Facilities)***	**Dr. Hess**
Reference Committee H ***(Health Care Data Systems)***	**Dr. Pulliam**

David W. Avery, M.D.
AMA Delegate

An overview of the HMSS Assembly Meeting

The 22nd AMA-HMSS Assembly Meeting was conducted December 2-6 in New Orleans with 412 credentialed representatives in attendance.

The AMA-HMSS considered 43 resolutions and 30 HMSS Governing Council reports. The Assembly action included: 24 resolutions adopted; five resolutions supported in lieu of a resolution; seven resolutions referred to the Governing Council, and seven resolutions not adopted. Of the Governing Council reports, 23 reports were adopted, six reports were filed, and one report was not adopted.

Ten of the resolutions were forwarded to the AMA House of Delegates for consideration at the 1994 Interim Meeting. In addition, the House considered four HMSS resolutions which were transmitted from the 1993 Annual Assembly Meeting.

The AMA House of Delegates adopted 11 of the HMSS resolutions, referred two resolutions to the Board of Trustees, and referred one resolution to the Board of Trustees for decision.

A resolution recommending review and updating of guidelines for medical staff bylaws was among the actions taken by the AMA House of Delegates. In lieu of Resolutions 107 and 148, the House of Delegates adopted Substitute Resolution 107 which asked the following:

> That the AMA reaffirm its Policy 165.960 (C) (1), in opposition to a National Health Board of the sort currently proposed by the Administration, and that Policy 165.945(1) (D) be amended by insertion and deletion to read as follows: "The AMA supports the creation of a National Health Advisory Body or Task Force that will form a public/private partnership including the AMA to recommend health policy."

In addition, the House of Delegates referred Resolution 822 to the Board of Trustees for report back to the House of Delegates at the 1994 Annual Meeting. This resolution called for the AMA to study the issue of physician representation in organizations such as group practices, independent practice associations, the physician component of a physician-hospital organization, physician networks, and other types of future arrangements that may form. It also requested the AMA designate the AMA-HMSS as the vehicle for providing representation to physicians providing services in these entities.

Another important action of the members of the House of Delegates was that they advised the AMA to oppose all efforts to open the National Practitioner Data Bank to public access. In addition, the members asked that the AMA strongly oppose public access to medical malpractice payment information in the National Practitioner Data Bank, and that the AMA oppose the implementation by the National Practitioner Data Bank of a self-query user fee.

Other topics of discussion at the meeting included conflict of interest among all components of the health care system and legislation to control handguns.

Norman W. Taylor, M.D.
Raleigh General Hospital Delegate to HMSS
Chairman, WVSMA-HMSS

Stabilization of hand phalangeal fractures by external fixator

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Abstract

The method of external fixation of phalangeal fractures provides a solution for extensive hand injuries where internal fixation may be prohibited due to compromised skin coverage or bone loss. Early mobilization of adjacent joints is possible with these devices and is fundamental for the preservation of hand function. This paper describes the proper selection of cases and the versatility of its application. Representative clinical uses are summarized.

Introduction

In hand injuries, the combination of skeletal fractures and severe soft tissue damage represents a difficult management problem, especially in comminuted phalangeal fractures with bone loss. External fixation is a modern method that provides stability and good alignment of the fracture (Figure 1) and permits early mobilization of adjacent joints.

This article describes three cases in which external fixation was used with good results and outlines the indications and technical details of these method.

Case reports

First case

A 15-year-old boy sustained severe trauma to his left hand from a piece of farm machinery. This patient was referred to the Department of Surgery at the Robert C. Byrd Health Sciences Center of West Virginia University in Morgantown one month later, with an infected wound on the dorsal aspect of the third and fourth digits, comminuted fractures of the proximal and middle phalanges, bone loss and damage to the proximal interphalangeal joints and extensor tendons (Figure 2a).

Debridement was performed, eliminating all necrotic tissue and the skin coverage was secured with a left groin flap (Figures 2b, 2c). To maintain finger length, a 3 cm. x 1 cm. cancelous bone graft was transplanted to each digit, obtained from the left ulna. An external fixator was utilized to allow the integration of the bone graft and early mobilization of adjacent joints. Offset pins were introduced at the base of the proximal phalanx and at the head of the middle phalanx to properly attach the external fixator (Figures 2d, 2e). The device was removed after two months and the patient regained good function (Figures 2f, 2g).

Second case

A 30-year-old man sustained a chain saw injury to the volar aspect of his left thumb, presenting to the Emergency Room at Ruby Memorial Hospital with an incomplete amputation at the level of the interphalangeal joint. The patient was subjected to debridement of the wound, immobilization of the fracture with an external fixator (Figure 3a), microanastomosis of one digitalartery, repair of both digital nerves and tenorraphy of the flexor policis longus.

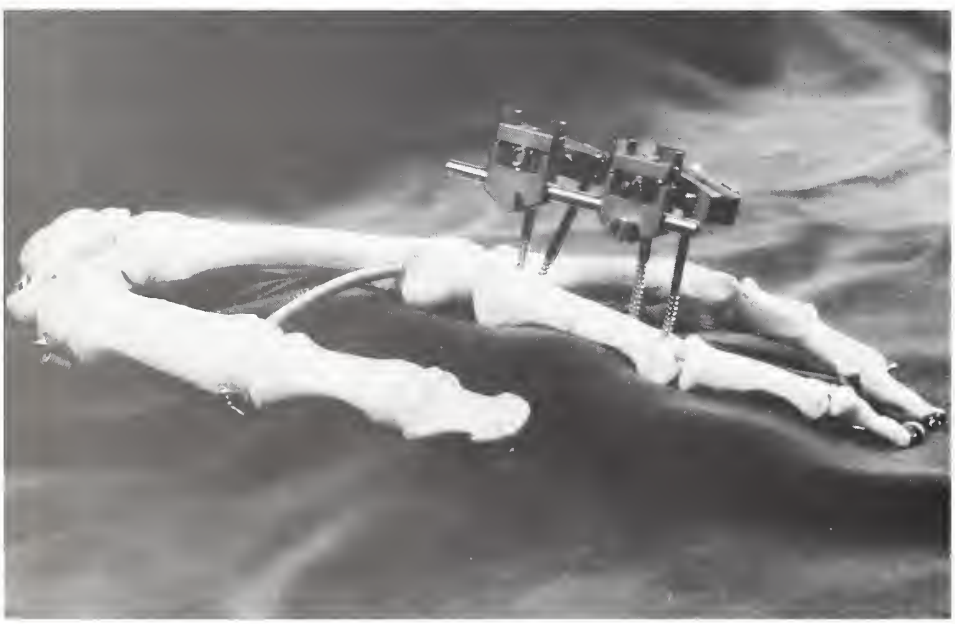

Figure 1. External fixator applied to an experimental model.

Figure 2A. An open comminuted fracture of the proximal and middle phalanx of the left hand of a 15-year-old male patient injured in a farm accident. Skin avulsion and infection are present.

Figure 2B. Site for a split groin flap for wound coverage.

Figure 2C. Flap ready for transection of the pedicles at three weeks, and bone alignment maintained with intramedullary K wires.

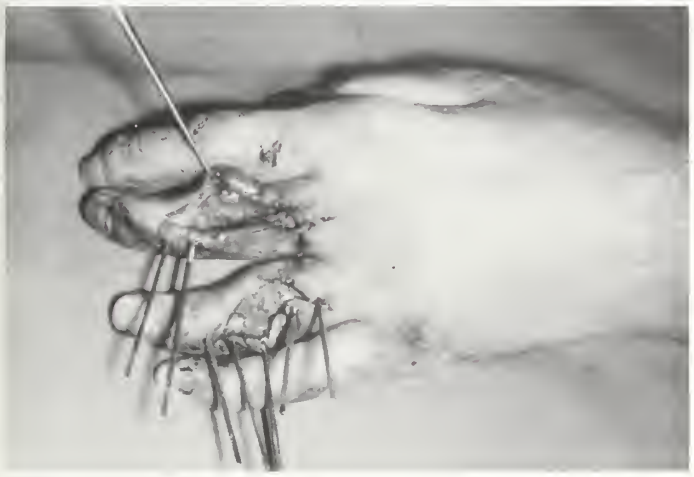

Figure 2D. Bone grafting and placement of offset pins.

The skin coverage became necrotic, exposing the flexor tendon (Figure 3b), requiring coverage which was transposed from the dorsum of the index finger (Figures 3c, 3d). The external fixator was removed in one month after consolidation of the fracture after the patient retained good function of the thumb (Figure 3e).

Third case

A 24-year-old man injured the fifth finger of his right hand in an industrial accident. He sustained a closed fracture at the base of the proximal phalanx and partial amputation of the distal phalanx (Figure 4a).

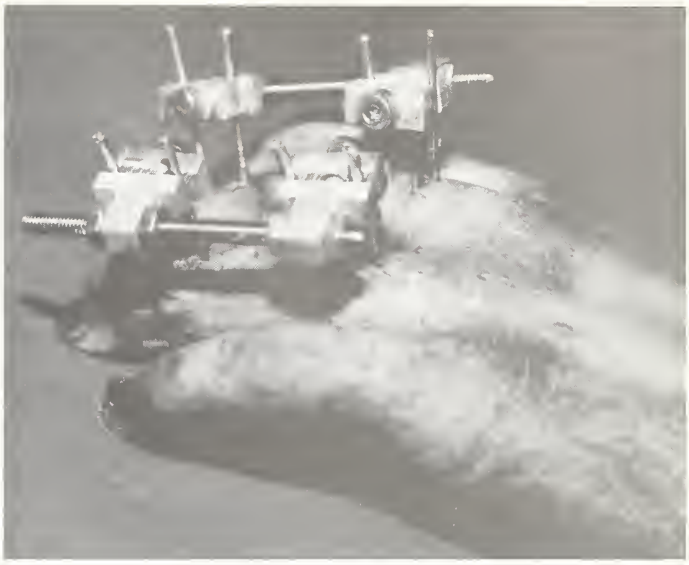

Figure 2E. Skeletal stabilization with the external fixator.

Figures 2F and G. (Above and below) Appearance and function of third and fourth digits of the left hand eight months after injury.

Figure 3A. Stabilization of a fracture of the distal phalanx and interphalangeal joint of the right thumb of a 30-year-old man injured with a chain saw.

Figure 3B. Skin necrosis and exposure of the flexor policis tendon two weeks after injury.

Figure 3C. Transposition of a dorsal skin flap.

Figure 3D. Flap insertion.

Figure 3E. Appearance of the distal phalanx and interphalangeal joint after treatment and demondtration of gripping ability.

After reduction of the fracture, an external fixator was applied for the purpose of stabilizing the fragments and allowing early mobilization of adjacent joints (Figures 4b, 4c). The device was removed after three weeks with normal function restored.

Operative technique

Under regional or axillary block anesthesia, one or two offset pins are inserted into each bony fragment. To avoid damage to the extensor tendon in a closed fracture, the skin is perforated first and the tendon is pushed aside by the tip of the pin.

Using a slow-speed power drill, the pins are inserted through the dorsal cortical and medullary bone up to the volar cortical bone, thus, avoiding damage to flexor tendons and neurovascular bundles. The pins are introduced transversely at a 90 degree angle to the long axis of the bone because the small diameters of the bones demand a meticulous insertion technique.

The fracture is then reduced by applying traction to the finger and mobilizing the proximal and distal fragments by external pressure. The fixator frame is assembled with pin holders, vises and connecting rods. Radiograms are used to assure proper alignment and to visualize the placement of the pin in small fragments. In an open fracture, the pins are placed to avoid wounds or contamination of the tissue (1).

Figure 4A. X-ray of a 24-year-old man showing an unstable closed fracture to the left fifth digit of the proximal phalanx and partial amputation of the finger tip after an industrial accident.

Figure 4B. Reduction and external fixation with two offset pins.

The wound and the sites of pin insertion are cleaned every day with mild soap. Antibiotic ointment is applied and the area covered with a sterile dressing. The patient is examined every fifth day to assure stability of the immobilization and to make necessary adjustments on the fixator.

Radiographic controls will be taken after one or two weeks and before removal of the frame. After a variable period of two to eight weeks, depending on the severity of the fracture or bony grafting, the device is partially disassembled and, if union is clinically evident, the device is withdrawn with local anesthesia.

Discussion

The method of external fixation widely used in the lower extremities (2) can now be readily utilized in complex hand injuries. In addition, internal fixation with K wires or micro plates and micro screws are good methods of stabilizing phalangeal fractures (3). However, if there is soft tissue compromise or bone loss they may not be the preferred method of treatment.

The primary indication for external fixation is the need for stability and alignment of fractures in which early mobilization of adjacent joints is necessary, and in fractures with bone loss that cannot be internally fixed (4). Anatomic restoration of the skeleton with stability

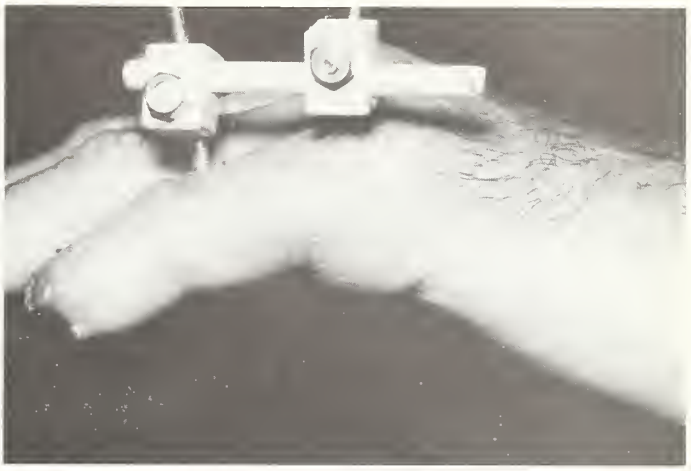

Figure 4C. Digit in good alignment.

allows joint motion and tendon excursion. Adequate control of small bony fragments is obtained where in-line pin placement is impossible in open fractures. The pins can be placed to avoid wounds or contaminate tissue, with a minimum of soft tissue dissection (5,6).

Temporary external fixation can be used for fracture management until wound condition permits the application of other means of osteosynthesis. The bones can be manipulated with compression of the fracture to create a gain in length or to hasten a delayed union.

Postoperative care requires strict compliance by the patient, involving elevation of the extremity and immediate active mobilization of the hand and fingers. Pin infections have been reported and may require antibiotic therapy and pin removal (5).

In 1974, Crockett (1) first described the technique of external fixation using K-wires bonded with methyl methacrylate resin. Several external fixation systems designed specifically for small bone injuries are commercially available. They present great versatility and the components are designed so that the fracture can be reduced after the frame is assembled, thus providing a high degree of control over the exact positioning of small bones (7).

Expertise in this method requires the surgeon to become familiar with the device and its assembly (8). The use of a skeletal model, where different types of fractures can be reproduced and immobilized with the external fixator, is of extreme value in training.

The method of external fixation provides a safe approach in selected cases when other means of fixation are inadequate.

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Rational treatment for dyslipidemias

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Abstract

High blood cholesterol is one of the three most common risk factors for cardiovascular disease. Several antihyperlipidemic agents are available to the prescriber; however, first line therapy is a diet low in cholesterol and saturated fats. The choice of therapy must be based on the type of abnormality present, concurrent disease states, side effect profiles, ease of use and cost. Several differences exist among the various dyslipidemic agents such as mechanism of action, effectiveness, pharmacokinetics, side effects, drug interactions and cost. For these reasons, this review focuses on the most commonly used dyslipidemic agents, e.g. the bile-acid sequestrants, nicotinic acid, fibric-acid derivatives and HMG-CoA reductase inhibitors.

Introduction

Cardiovascular disease (CVD) is one of the major causes of mortality in the United States, accounting for almost one in every two deaths. This is true even though deaths from heart attacks and strokes have decreased since the early 1970s. Yet, more than 4 million Americans have experienced a heart attack or stroke that has compromised their quality of life (1).

Three major risk factors for CVD are smoking, high blood pressure and high blood cholesterol. Other risks include obesity, diabetes, family history, reduced high density lipoprotein (HDL) cholesterol (< 35mg./dL), and male gender (1). Although many of the risk factors cannot be modified, studies have shown that lowering cholesterol levels decreases the chance of experiencing a major cardiac event (2).

The National Cholesterol Education Program (NCEP) established guidelines based on levels of total cholesterol and low density lipoprotein (LDL) cholesterol for the diagnosis and treatment of high blood cholesterol in adults. LDL is the primary target for cholesterol-lowering strategies, and low HDL is also a risk factor for CVD (2). The NCEP recommends that patients should be initially treated with exercise, diet, and weight reduction (3). Many patients can be controlled using this regimen alone, but some may need drug therapy. There are several different drugs available for treating dyslipidemias, and each has a particular indication. Table 1 lists the agents currently available for the treatment of hyperlipidemia.

There are five types of dyslipidemias based on elevations of cholesterol, triglycerides, or both, and defects in lipoproteins (4). They are as follows:

Type I	Very high triglycerides
Type IIa	High cholesterol
Type IIb	High cholesterol and triglycerides (LDL and VLDL elevated)
Type III	High cholesterol and triglycerides (intermediate density lipoprotein elevated)
Type IV	High triglycerides and normal to slightly high cholesterol
Type V	Very high triglycerides and cholesterol

Although probucol (Lorelco®) and dextrothyroxine (Choloxin®) have been listed in Table 1 for completeness, they will not be included in this discussion. These medications are seldom used since the advent of newer treatments. Thus, this discussion will focus on the bile acid sequestrants, nicotinic acid, fibric acid derivatives and the 3-hydroxy-3-methylglutaryl coenzyme A (HMG-CoA) reductase inhibitors.

Bile-acid sequestrants

Mechanism of action

Cholesterol is the major precursor of bile acids which are secreted via the bile from the liver and gall bladder during normal digestion. In the intestines, bile acids emulsify the fat and lipid materials in food, thus facilitating absorption. The bile-acid sequestrants, cholestyramine (Questran®) and colestipol (Colestid®), lower cholesterol by binding with bile acid in the intestines. Subsequently, an insoluble complex is formed which is then excreted in the feces. Thus, a partial removal of bile acids from the enterohepatic circulation occurs, preventing absorption.

Bile acid sequestrants cause an increase in hepatic cholesterol synthesis, but the plasma cholesterol levels decrease secondary to an increased rate of clearance of cholesterol-rich lipoproteins from the plasma. In addition, serum triglyceride (TG) levels may increase by 5 percent to 20 percent in the first few weeks of therapy; however, TG levels will return to pretreatment values within four weeks of discontinuing treatment.

Pharmacokinetics

Bile-acid sequestrants (anion exchange resins) are hydrophilic, but insoluble in water. Systemic absorption does not occur because these agents remain unchanged in the GI tract.

TABLE 1. Agents for hyperlipidemia

Bile Acid Sequestrants	**HMG-CoA Reductase Inhibitors**
- cholestyramine	- lovastatin
- colestipol	- pravastatin
	- simvastatin
Nicotinic Acid	**Probucol**
Fibric Acid Derivatives	**Dextrothyroxine**
- gemfibrozil	
- clofibrate	

LDL cholesterol (LDL-C) levels will begin to decrease within four to seven days of treatment, resulting in a total reduction in LDL cholesterol of 20 percent. The response to treatment is usually evident after one month of therapy. Consequently, upon discontinuation of therapy, pretreatment LDL-C levels return after one month.

Effectiveness

In Type IIa hyperlipoproteinemia, colestipol is more effective than clofibrate in lowering total and LDL-C, with no effect on HDL-C. If optimal response to colestipol alone is not achieved, especially in heterozygous familial hypercholesterolemia, the addition of nicotinic acid (Niacin) will effectively lower serum cholesterol, TG, and LDL-C, while increasing HDL-C significantly. Further results at lowering cholesterol levels have been achieved with the bile sequestrants and lovastatin (Mevacor®).

Studies have shown a reduction in the rate of CHD death and non-fatal MI with administration of bile-acid sequestrants. In a large, multiclinic study, a 19 percent reduction in the combined rate of CHD death plus non-fatal MI (cumulative incidences of 7 percent cholestyramine and 8.6 percent placebo) was seen during a 7-year study period. Subjects were middle-aged males (ages 35 to 59) with serum cholesterol levels greater than 265 mg./dl. and no previous history of heart disease.

Side effects

Constipation is the most common adverse effect. This can occur in up to 10% of patients and at times can be severe, leading to fecal impaction.

Other gastrointestinal effects are less common, e.g. abdominal pain, bloating, flatulence, nausea, vomiting, indigestion, and diarrhea. Hyperchloremic acidosis and increased urinary calcium excretion may also occur.

Drug interactions

The bile acid sequestrants may delay or reduce the absorption of concomitant oral medications by binding to drugs in the GI tract. To avoid decreased absorption, separate other medications from the bile-acid sequestrants by one hour before a dose or four to six hours after a dose.

Dosing times are most critical with drugs having a narrow therapeutic index, such as warfarin (Coumadin®), digoxin (Lanoxin®), thyroid hormones, and corticosteriods. Other agents to consider include acetaminophen (Tylenol®), naproxen (Naprosyn®), piroxicam (Feldene®), propranolol (Inderal®), thiazide diuretics, and ursodiol (Actigall®). Malabsorption of the fat-soluble vitamins (A,D,E, and K) can occur with these agents, especially when given for prolonged periods of time. Supplementation with water-miscible (or parenteral) forms of vitamins A and D may be required.

Administration

The lipid-lowering effect of 4 g. cholestyramine equals 5 g. colestipol. Adult doses should be individualized and although generally given three to four times daily, no apparent advantage is seen from dosing these agents more than twice daily (Table 2). Patients should be told to take these medications before meals, mixing them with beverages, highly fluid soups, cereals or pulpy fruits.

Nicotinic acid

Mechanism of action

Nicotinic acid or niacin is a B vitamin. Although the exact mechanism of action of lipid lowering is unknown, nicotinic acid inhibits lipolysis in adipose tissue, decreases esterification of triglyceride in the liver and increases lipoprotein lipase activity.

Effectiveness

At doses of 3 to 6 grams daily, nicotinic acid reduces LDL and VLDL cholesterol and TG by 20 to 40 percent in 1 to 7 days; maximal effect on LDL is seen after three to five weeks of therapy. HDL-C is increased by 20 percent (6).

Pharmacokinetics

Nicotinic acid is rapidly and nearly completely absorbed in the intestines. Peak plasma levels are reached in 45 minutes. Renal excretion predominates; urinary excretion of a 3 g. dose is 88 percent.

Side effects

Adverse effects are predominantly dose-related with the most common being gastrointestinal upset, flushing, and pruritus. Flushing occurs within 20 minutes of administration and may last for 30-60 minutes. The frequency and severity generally subside with continued therapy. One 325 mg. tablet of aspirin may reduce the incidence of flushing.

Although extended-release products of niacin are available, they have not been shown to cause less flushing, and they can be associated with more GI side effects. Niacin has also been found to cause glucose intolerance and liver toxicity, therefore it is not the drug of choice in diabetic patients, and periodic liver function tests need to be performed.

Administration

To reduce the incidence of side effects, niacin should be given in low, divided doses on a full stomach or with

Table 2. Summary of antihyperlipidemic agents. doses and costs

Generic Name	Brand Name	Dose	Cost*	Effect
Cholestyramine	Questran Questran Light Cholybar	4 g. given 1-6 times/day	$22.80-$136.80 $22.80-$136.80 $33.36-$200.16	↔↑TG, ↓LDL ↔↑HDL, ↓TC
Colestipol	Colestid	5-30 g. QD or in divided doses	$20.78-$124.70	↔↑TG, ↓LDL ↔↑HDL, ↓TC
Nicotinic Acid	Niacin	1-2 g. TID with meals	$11.07-$22.14	↓TG, ↓LDL ↑HDL, ↓TC
Gemfibrozil	Lopid	600 mg. BID taken 30 minutes before meals	$60.20	↓TG, ↔↓LDL ↑HDL, ↓TC
Lovastatin	Mevacor	20-80 mg./day in single or divided doses	$55.30-$199.03	↔↓TG, ↓LDL ↔↑HDL,↓TC
Pravastatin	Pravachol	10-40 mg. bedtime	$47.11-$99.83	↔↓TG, ↓LDL ↔↑HDL, ↓TC
Simvastatin	Zocor	5-40 mg./day in the evening	$47.24-$140.97	↔↓TG, ↓LDL ↔↑HDL, ↓TC

* Cost for 30 days of therapy according to AWP listing in Redbook 1993 (priced from lowest to highest dose per day)

↑ = increase
↔ = unchanged
↓ = decrease
TG = triglyceride
LDL = low density lipoprotein
HDL = high density lipoprotein
TC = total cholesterol
QD = once daily
TID = three times daily
BID = twice daily

antacids. In addition, doses should be titrated gradually, starting with 1 to 2 g. per day given in divided doses, three times per day with a maximum daily dose of 8 g. Substantial effects on LDL, TG, and HDL are usually seen with doses of 3 to 6 g. daily (3).

Fibric-acid derivatives

Mechanism of action

The mechanism by which the fibric-acid derivatives work has not been definitely established. Gemfibrozil (Lopid®) appears to inhibit peripheral lipolysis and decrease hepatic extraction of free fatty acids, thereby reducing hepatic TG production.

Effectiveness

In the Helsinki Heart Study, treatment with gemfibrozil resulted in a 34% decrease in serious coronary events and a 37% decrease in non-fatal MI (7). Greatest reductions occurred in patients with both elevated LDL-C and triglycerides.

Pharmacokinetics

Both agents are well absorbed and the onset of action is two to five days. These agents are largely renally eliminated so that decreased doses may be needed in those with decreased renal function, although specific doses have not been recommended.

Side effects

Adverse reactions which occur with these agents include dyspepsia (19.6%), abdominal pain (9.8%), diarrhea (7.2%), nausea/vomiting (2.5%), fatigue (3.8%), vertigo (1.5%), headache (1.2%), and eczema (1.9%). Administration may also lead to gallstone formation and should be discontinued if this occurs.

Although transient liver function abnormalities (increased transaminase, creatine phosphokinase, lactic dehydrogenase, bilirubin and alkaline phosphatase) may occur, they are usually reversible upon drug discontinuation. Nevertheless, periodic (annual) liver function studies should be monitored and therapy should be discontinued if abnormalities persist.

Drug interactions

Clofibrate and gemfibrozil may potentiate the anticoagulant effects of oral anticoagulants (e.g. warfarin), so the prothrombin time should be closely monitored. Appropriate dose adjustments should be made during, and for several days following the initiation of concomitant therapy, until prothrombin time has stabilized.

In addition, gemfibrozil should not be used with lovastatin due to an increased risk of severe myopathy, rhabdomyolysis and acute renal failure (5).

Administration

Gemfibrozil should be administered 30 minutes before the morning and evening meals (Table 2). Therapy should be withdrawn if no response has occurred after three months of therapy.

The manufacturer recommends that clofibrate be taken with food to minimize stomach upset.

HMG-CoA reductase inhibitors

Mechanism of action

Lovastatin (Mevacor®), pravastatin (Pravachol®), and simvastatin (Zocor®) lower total and LDL-C by inhibiting the enzyme HMG-CoA reductase. This enzyme converts HMG-CoA to mevalonate, which is an early and rate-limiting step in cholesterol biosynthesis (8).

Effectiveness

There are only a few studies which have compared these agents; therefore, it is difficult to determine whether any of these medications are more effective or safer than the others (8). Long-term studies have yet to establish the effects of these agents on cardiovascular morbidity and mortality.

As monotherapy, the HMG-CoA reductase inhibitors are the most potent total and LDL cholesterol-lowering agents and are usually the best tolerated (9).

Pharmacokinetics

All of these agents undergo extensive first-pass extraction by the liver. Lovastatin and simvastatin are both extensively bound to protein, while pravastatin is only 50% bound.

Pravastatin is active when given orally, whereas, lovastatin and simvastatin are prodrugs and need to be hydrolyzed to their active forms. Plasma concentrations of lovastatin are significantly decreased when given on an empty stomach. Pravastatin and simvastatin are not effected by the presence or absence of food in the stomach.

All three agents are eliminated by both the fecal and renal route; however, the fecal route predominates (8).

Side effects

Concurrent administration of gemfibrozil and lovastatin has produced myopathies and rhabdomyolysis. This may also occur with pravastatin and simvastatin, so the concomitant use of these agents with gemfibrozil, niacin, erythromycin, and immunosuppressants should be carefully monitored (8). In addition, concurrent use of digoxin and simvastatin may lead to slight elevations in serum digoxin levels.

Lovastatin and simvastatin have been shown to increase the effects of warfarin, but this has not been reported with pravastatin, but precautions should be taken when using any HMG-CoA reductase inhibitor with warfarin. These agents also cause transient elevation of liver transaminases, so periodic liver function tests should be performed.

Lovastatin has been reported to cause lens opacities, blurred vision, insomnia, and impotence (10). Pravastatin has been reported to cause blurred vision but not insomnia or impotence (11), and simvastatin has not

Table 3. Effects and precautions of anti-hyperlipidemic agents

Drug Name	Reduce CHD?	Long-Term Safety	LDL-C Decrease	Special Precautions
Cholestyramine	yes	yes	15-30%	Increase TG
Colestipol	yes	yes	15-30%	Increase TG
Nicotinic Acid	yes	yes	15-30%	Test for hyperuricemia hyperglycemia, and LFTs
Lovastatin	not proven	not established	25-45%	Monitor LFTs
Pravastatin	not proven	not established	25-45%	Monitor LFTs
Simvastatin	not proven	not established	25-45%	Monitor LFTs
Gemfibrozil	yes	preliminary evidence	5-15%	May increase LDL-C in hypertriglyceride patients; don't use in those with gallbladder disease, monitor LFTs

* CHD = coronary heart disease
LDL-C = low density lipoprotein cholesterol
TG = triglyceride
LFTs = liver function tests

Table 4. Anti-hyperlipidemic agents for the major classes of hyperlipidemia (4)

Type of Hyperlipidemia	Agents Indicated
Hypercholesterolemia alone	Bile acid sequestrants
	Nicotinic acid
	HMG-CoA reductase inhibitors
Hypertriglyceridemia alone	Nicotinic acid
	Fibric acid derivatives (gemfibrozil)
LDL-C and hypertriglyceridemia	Nicotinic acid
	HMG-CoA reductase inhibitors
	Fibric acid derivatives (gemfibrozil)

LDL-C = low density lipoprotein cholesterol; HMG-CoA = 3-hydroxy-3-methylglutaryl coenzyme A

been reported to cause any of these three side effects (12). Since lovastatin has been available for a longer period of time, one should still monitor patients for similar side effects when prescribing pravastatin and simvastatin.

Administration

Lovastatin should be given with meals at doses of 20 to 80 mg. per day in single or divided doses. Pravastatin and simvastatin can be given once daily without regard to meals (Table 2).

In addition, patients with significant renal or hepatic dysfunction and the elderly should be started at one-half of the usual initial dose for all of HMG-CoA reductase inhibitors (10-12).

Conclusions

Today, there are many effective agents for treating hyperlipidemia. Although first line therapy is a diet low in cholesterol and saturated fats, a rational approach to drug therapy is required when diet therapy fails. The choice of an agent should be based on the type of abnormality present, concurrent disease states, and side effects.

Combination drug therapy should be considered only after compliance with a single-drug regimen has been documented. The most effective combination for reducing total cholesterol and LDL cholesterol are the HMG-CoA reductase inhibitors with a bile-acid sequestrant or niacin with a bile-acid sequestrant.

Tables 2-4 illustrate comparisons of the various agents for hyperlipidemia. It is important to remember therapy should be initiated only after secondary causes have been ruled out and diet therapy has failed.

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Manuscript Guidelines

All scientific manuscripts should be submitted on an IBM compatible disc in Wordperfect 5.1 or in ASCII (generic). They must be prepared in accordance with *"Uniform Requirements for Manuscripts Submitted to Biomedical Journals."*

Papers will not be considered for publication if they have already been reported in a published paper or are described in a manuscript submitted or accepted for publication elsewhere. They should be accompanied by one extra copy, be double-spaced on white bond paper, and have the page numbers printed in the right-hand corner of each page.

All manuscripts should include:

1. Title page
2. An abstract of no more than 150 words
3. Text
4. Acknowledgements
5. References in parentheses numbered consecutively. No more than 25 references will be published free of charge.
6. Tables
7. Legends for illustrations

All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the concept.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing its most commonly known trade name.

Tables (tabular listings) and figures (photos, drawings and charts) should be numbered, and the point of reference in the text indicated in parentheses, i.e. (Table 1), (Figure 10). Photos must be unmounted glossy prints in a 5 in. x 7 in. format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be done in solid black on pure white.

All scientific material is reviewed by the Publication Committee and should be sent to The Editor, West Virginia Medical Journal, P.O. Box 4106, Charleston, WV 25364.

Contact Nd:YAG laser excision of rhinophyma

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Abstract

Rhinophyma, an excessive hyperplasia of the sebaceous glands of the nose, results in disfigurement, occasional nasal blockage and recurrent infection. This condition is considered to be the culmination of acne rosacea and can degenerate to a basal cell or squamous cell carcinoma (1). Various surgical methods have been used to treat rhinophyma, but most have resulted in complications and poor cosmetic outcomes. Wenig and Weingarten (6) reported four cases of rhinophyma which were successfully treated with the contact Nd: YAG laser, and this article describes my experience in use of this modality to treat a 71-year-old patient at the Eye and Ear Clinic of Charleston.

Introduction

Rhinophyma was described by Hebra in 1845 as an excessive hyperplasia of the sebaceous glands of the nose resulting in disfigurement, occasional nasal blockage and recurrent infection. It is a slow overgrowth with uncertain etiology and unrelated to alcohol intake. Rhinophyma is considered to be the culmination of acne rosacea and can degenerate to a basal cell or squamous cell carcinoma (1).

Treatment of rhinophmya is surgical and classified as complete excision with skin grafting and controlled excision with secondary epithelial regeneration (2). Various surgical methods such as cryosurgery, electrocautery, dermabrasion (3), and non-contact laser therapy (4,5) have been used for rhinophyma with high instances of complications and poor cosmetic results. Wenig and Weingarten reported four cases of rhinophyma which were successfully treated with the contact Nd:YAG laser (6).

The SLT contact Nd:YAG laser system, which was developed by Surgical Laser Technologies in Oakes, Pa., has been used since 1988 in 90% of the head and neck procedures at the Eye and Ear Clinic of Charleston because of its precision, controllability, atraumaticity, facility, hemostasis, and acicatrization (7).

Case report

A 71-year-old white man was referred by a dermatologist for a growth which had been on his nose for five years. This growth was associated with an oozing of sebum and painful intermittent infection. The patient was taking an anticoagulant due to a previous history of stroke. Examination disclosed an exuberant overgrowth of sebaceous glands of the entire external nose with partial blockage of the nares (Figure 1). Punctate areas of sebum were observed and the diagnosis was rhinophyma.

Technique

Under propofol (Diprivan) intravenous analgesia, the bulk of the rhinophyma was excised using a contact Nd:YAG laser 0.6 mm. frosted sapphire scalpel screwed onto a general handpiece set at 12 watts continuous mode. As shown in Figure 2, the light touch technique was utilized for effective and atraumatic tissue excision. Areas of residual rhinophyma were polished in a brushing manner with a vaporizing probe. Preservation of normal anatomy, especially of the alar area is mandatory to prevent contracture and notching. Sebaceous materials crackled under vaporization and constant suctioning was required to remove odor and smoke. Minimal bleeding was observed with this technique.

After completion of the excision, the wound was covered with collagen pad dressing impregnated with Chloroelase ointment. The dressing was changed weekly till complete epithelial regeneration was achieved in 12 weeks. Retouching with a vaporizing probe was done at two-month

Figure 1. Exuberant rhinophyma.

Figure 2. Use of the contact Nd:YAG laser.

Figure 3. Residual crusting after 10 weeks.

Figure 4. Complete healing in 12 weeks.

intervals for rhinophyma residues. Crusting persisted for eight weeks and it was managed with hydrogen peroxide cleansing and Chloro-elase ointment collagen pad application (Figure 3). No complications arose during a six-month follow-up with excellent functional and cosmetic results (Figure 4).

Discussion

The contact Nd:YAG laser sapphire probes, which were developed by Daikuzono (8) in 1985, provide a versatile cutting and coagulating tool with precision, controlled tissue penetration (0.5 mm.), concentrated power density and minimal tissue injury. In the non-contact mode, more tissue damage and necrosis ensue because of higher power output requirement and uncontrolled scattering. The contact Nd:YAG laser probes are applied directly to tissues so the surgeon is afforded a tactile feedback and focusing is not required. It can coagulate blood vessels of one mm. diameter, creating a bloodless field.

Compared to the CO_2 laser, the contact Nd:YAG laser system is less cumbersome, more precise and more effective because it can cut in the presence of fluid. It also creates less fumes, less tissue damage, and promotes prompt healing and reduced operating time.

Conclusion

Conventional methods of rhinophyma surgery are fraught with excessive bleeding, imprecise excision and poor healing with unsatisfactory cosmetic results. At this time, the contact Nd:YAG laser is the best tool for surgery of rhinophyma because of its ability to cut accurately, as well as promote efficient coagulation and prompt healing.

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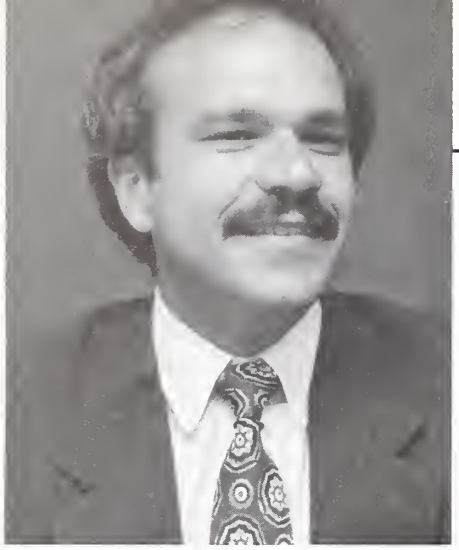

James L Comerci M.D.

Tinkering with the equation for access

As we move towards health system reform, it seems as though we keep taking steps backwards. I'm sure you're very familiar with a few of these steps which the federal government obviously deems as progress.

Take for example CLIA. This legislation will certainly clean up the physician office lab problem. (Was there a problem?) In fact, now there are so many tons of paperwork, so many duplicate records to keep, and so many other hassles that office labs will probably cease to exist.

And what about Medicare? This efficiently designed system now makes you bill separately for durable medical equipment provided in your office. The goal of this ridiculous practice, as one Medicare official stated it, is to have physicians include the DME in the global fee or simply not offer this service to avoid the hassle. Great cost containment.

Most of us realize that regulations such as CLIA and separate billing for durable medical equipment only make delivery of medical care more difficult, and we must continue to show how these measures reduce access to care for our patients. It is very questionable as to whether these regulations are designed to control cost or access.

Speaking of access, many stabs are taken at solving this problem by suggesting that any access problem can be solved by increasing the number of primary care physicians and mid-level practitioners (PAs and nurse practitioners). While this may increase access at first, we must also look at the long-term effect and proceed with caution.

Increasing the number of primary care physicians at the risk of reduction in our pool of specialists may slow the enormous advances in medical care that we have come to expect. Incentives for rural practice and residency quotas may discourage students from choosing the fields they are most interested in pursuing. Forcing students into molds, whether they are doctors or engineers, will only make unhappy professionals. Encouraging primary care is a good option and finding ways to make rural practice rewarding and financially feasible will ultimately produce better results.

The puzzle of access to medical care has so many angles that at times it seems unsolvable. In fact, I might agree that access to medical care for most Americans is not a problem. We must admit that for some, access to medical care beyond basic, acute or emergency care, is a problem because of cost. Some people may choose to be in this financial situation, but others have no choice.

It is critical that we offer solutions to the problem of access very carefully because unlimited access to medical care can be extremely costly. It is obvious that we must look for ways to control access or to make it more efficient. A strong health care team must be the basis for improving the problems we may have with access, and each team member must recognize his or her role. Physicians must accept their responsibilities as leaders of the health care team and improve team performance.

Nurse practitioners and physician assistants are also vital parts of the health care team, and we must continue to find ways to work together in collaborative arrangements to deliver patient care. All too often, however, it is argued by government that nurse practitioners and physician assistants can replace physicians. Their training, though, is not the same, and if their training is not equal to that of physicians, the products will always be much different.

We must work together to refine, not replace our delivery system in order to serve the best interests of our patients.

James L. Comerci, M.D.

The Pitchmen

They must think that Alzheimer's is endemic in the Medicare crowd. How else to account for the flapdoodle directed by the Clinton administration to the elderly?

The pitch is, "Our health care reform will improve your Medicare benefits! We will give you long-term care and full therapeutic drug benefits in addition to what you receive now. On top of that, we will save $124 billion from what we presently are paying for your care."

Memories of a side-show barker come to mind. "Yes, indeed folks. Just step right up and see how we are going to do all this through federal government efficiency. Genuine efficiency! No tricks. No gimmicks. Just honest government efficiency . . ."

It doesn't take a rocket scientist to recognize this hoax. A genuine Alzheimer's sufferer might find it not too difficult to fathom. The subject to be avoided among the crowd by this glib pitch is RATIONING.

Of course, they can save $124 billion dollars. They can save more than that if they have a mind to . . . make the waiting list a little longer in any of a number of surgical or diagnostic procedures. Their thinking goes, "It's very expensive to keep these old folks alive. So, a few of them die waiting . . . they probably would have died no matter what. Just look at the nice effect it has on the cost of medical care though. That's efficiency!"

Government efficiency! A prototypal example of an oxymoron. Government efficiency indeed! A bureaucracy beyond anyone's wildest nightmare is what we will get.

Politicians love bureaucracies! Bureaucratic employees are all voters and they are beholden to those legislators who create, maintain and feed the bureaucracies. Once a bureaucratic job has been created, there is zero motivation to do away with it ever -- no matter the evidence there might be that the job is not needed, a needless expense, a liability. It is a vote!

A recent example of government efficiency at work is the Federal Aviation Administration, the bureau in charge of air traffic safety. The airlines, those most affected, have expressed unanimous agreement that the FAA should be abolished. One reason given is that it takes the FAA so long to develop, approve and purchase safety devices and equipment that by the time the equipment is installed, it is hopelessly out of date. Can you translate such government efficiency to medical care?

The administration seems to suggest that the answer to the FAA problem is the establishment of a government-owned corporation along the lines of AMTRAK. God help us! Especially all those trusting and secure-feeling airline passengers.

We can never afford to listen to liars and con artists or those political leaders whose political success is based on lies and con artist techniques. We particularly cannot afford to listen to these hucksters as they play a financial shell game with medical care costs, medical care availability and medical care quality. Too much is at stake. The medical care system is at stake. People's health and comfort, their very lives are at stake.

When the quality of medical care is diminished in any manner or the availability of care is limited through any form of rationing, millions are put in mortal jeopardy.

It is time that something other than dollars is talked about!

– Stephen D. Ward
Editor

Non-game wildlife programs

In February 1992, we first spoke favorably about the West Virginia non-game wildlife programs. Permanent and adequate funding for these programs is now being sought by concerned groups who are submitting legislation this session.

Environmental concerns promoted in this effort have peculiar importance for our state. West Virginia has few things going for it aside from those provided by the Lord through his initial gift of nature's kindest and best assets. Our hills, valleys, streams, wildlife, and the flora and fauna that grace these hills are unmatched by any other state.

If through neglect we allow our state government to treat Nature the way it treats business and professions, West Virginia will soon become an arid and lifeless wasteland.

We join with other concerned groups in encouraging the West Virginia Legislature to assure non-game wildlife programs a steady, predictable and assured source of funding so that their important and valued work can continue and grow.

– Stephen D. Ward
Editor

Special Correspondence

James Todd, M.D.
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Dear Dr. Todd:

I telephoned you last spring to express my concern to you that the AMA was not demanding more of a role in shaping the future of health care. You reassured me.

As I have watched developments since then, I have become convinced that the Clinton plan boils down to something very simple: big government control. To do this they plan to cap the amount of money going into the system, and force physicians to do the rationing as best we can work it out among ourselves. This is fundamentally unacceptable, but it becomes frankly intolerable with no meaningful tort reform and with the government continuing to promise more than it can deliver.

It is indeed unfortunate that we have allowed such words as "crisis" and "reform" to dominate the discussion. We have some problems with health care, but we certainly do not have a "crisis." That is baloney! Moreover, many (if not most) of the problems we do have can be traced to excess government intrusion, along with manipulation of the marketplace by the government and by insurance companies.

Why does the AMA not advocate free market approaches such as medical savings accounts, etc., as proposed by Senator Phil Gramm? That certainly makes more sense than prescribing an increased dose of the governmental and bureaucratic poison that has already caused the illness.

Unless the American Medical Association promptly declares its total dissatisfaction with the Clinton plan, I don't believe it is adequately serving its membership, and it is certainly not serving the American public.

Sincerely yours,
Fred F. Holt, M.D.

cc: WVSMA AMA Delegates and others

Fred F. Holt, M.D.
3100 MacCorkle Avenue, SE
Charleston, West Virginia 25304

Dear Dr. Holt:

Thank you for taking the time to express your views to me and the American Medical Association (AMA) regarding health system reform. The AMA believes that physicians and their representative organizations need to be fully involved in development of health system reform. No one knows better than physicians the strengths and weaknesses of our current system. Only by actively including the medical profession in the reform debate will an appropriate balance of cost, quality, and choice be maintained.

The AMA seeks reform that is well-founded and retains the excellence of our present system, not reform that is bureaucratic, centrally controlled, and steeped in governmental arrogance. We are willing to work with all parties; we will keep a positive public image, but we must not proceed in a manner that would jeopardize the patient-physician relationship, or the tradition of excellence of the medical profession.

During the past year, the AMA has been very actively involved with the White House Task Force on National Health Care Reform, the Administration, and the Congress. We have advocated physicians' views at numerous meetings. But physicians are not the only group that has a stake in this issue. Many groups are "fed up" with health care costs and want drastic action. Our job is to communicate, advocate, and educate, as best we can. The AMA is working hard at that.

The AMA believes that this is just the beginning of a long campaign to achieve the best possible reform for patients and physicians, and many ideas will be considered and debated as reform legislation is moved through the Congress. I hope that you will take every opportunity to make your views known to members of your community and your legislative representatives. By voicing your opinion, you can help shape the direction of health system reform.

Thank you for taking the time to communicate your views. It is heartening to know that busy physicians care enough to take the time to give attention to the impact of health system reform proposals. Thank you for your membership in the AMA. Be assured that the AMA is working diligently. It is our hope that all physicians will also lend their voices so that the best possible reforms are adopted.

Sincerely,
James S. Todd, M.D.

Be on the inside of health system reform

Come to Washington on March 8

Join us and make a difference

Partnership in Action: Uniting for America's Health

When reform proposals take shape, will your views be included? Specific health reform proposals are being hammered into policy in our nation's capital. Now is the time to ask questions and voice concerns.

The American Medical Association will host an interactive meeting of key congressional policy makers and physicians from across the country. *Partnership in Action: Uniting for America's Health* takes place March 8 in Washington, DC.

March 8 will be a day filled with interactive dialogue between policy makers and the physicians who will be affected by those policies. Dinners will feature roundtable discussions with congressional members from coast to coast.

Your presence at the 1994 summit can make a difference. To register now, call 800 262-3211.

American Medical Association

Physicians dedicated to the health of America

Huntington site for 42nd WVAAFP assembly

The 42nd Annual Scientific Assembly of the West Virginia Chapter of the American Academy of Family Physicians is set for April 8-10 at the Radisson Hotel in Huntington, with special preconference events on Thursday, April 7.

This year's first preconference event will be the 13th Annual Golf Tournament at Lavalette Golf Club, which will tee off at 11 a.m. on April 7. That afternoon, a luncheon will be held from 12:30 p.m. - 1:30 p.m., and then, Harold Preston, president of Physicians Practice Management, will conduct a seminar entitled "Advanced Techniques in Billing and Coding for Family Physicians." The next scheduled event for this day is an "Obstetrical Update," sponsored by the Charleston Area Medical Center from 6:30 p.m. - 9 p.m. In conjunction with this seminar, a buffet dinner is being held at 5:30 p.m.

On Friday morning, the conference will officially kickoff at 7 a.m. with registration and a continental breakfast. The first lecture, "Management of Benign Prostatic Hyperplasia," will then be delivered at 8:30 a.m. by James B. Regan, M.D., of Georgetown University Medical Center in Washington, D.C. Immediately following, W. James Howard, M.D., of Washington Hospital Center in Washington, D.C., will speak on the subject of "Which Lipid Factors Are Important from the Family Physician's Perspective." The third speaker that morning be David Pitts, M.D., of the Chattanooga Cardiovascular Risk Prevention Clinic, who will discuss "Antihypertensive Agents: Their Effects on Lipids, Glucose and Renal Function." This morning session will then conclude with the lecture "Diagnosis and Treatment of Migraine Headaches" by Aubrey L. Knight, M.D., of the University of Virginia.

After lunch, Friday's presentations with reconvene with a lecture on "Diagnosis and Treatment of Common Fungal Infections" by Stephen Brozena, M.D., of the James A. Haley Veterans Hospital in Tampa, Fla. Holly Harris, M.D., of South Bend Clinic in South Bend, Ind., will then present a talk on "Pediatric Dermatology." The final speaker for this afternoon session will be Gary Stein, Pharm.D., of Michigan State University, who will discuss "Vaginal Candidiasis." The day's activities will conclude with alumni and all member parties.

Harris

Gambrell

Hatfield

Registration and a continental breakfast will again begin at 7 a.m. on Saturday. Three different meetings will then take place at 7:15 a.m. -- the Sports Medicine Committee Breakfast Meeting, the Resident Directors Breakfast Meeting, and the Women in Family Medicine Breakfast. Following these events, a "Seminar on Women's Health Issues" will be held at 8 a.m. Topics to be discussed include "Benefits and Risks of Estrogen-Progestogen Replacement Therapy," by R. Donald Gambrell Jr., M.D.; "Heart Disease in Women," by Elizabeth B. Connell, M.D.; "Abnormal Vaginal Discharge: Obstetrical and Gynecological Consequences," by Doris Brooker, M.D.; and "The Role of Hormones in Etiology and Prevention of Endometrial and Breast Cancer," by Dr. Gambrell.

After a break for several special luncheons, Dr. Connell will again speak to participants and this time her topic will be "Contraception Alternatives for the 90s." Another speaker from the morning lectures, Dr. Brooker, will then discuss "Prevention of Physician Misconduct." The final speaker for the afternoon will be R. Mark Hatfield, M.D., who will address the subject of "The Diabetic Eye." Following these lectures, a cocktail party, the annual banquet, and an after dinner dessert/cordial party are planned.

Sunday's activities will begin at 7 a.m. with complimentary SMAC-20s by SVI. Then, after registration and a continental breakfast at 7:30 a.m., four lectures are scheduled. The topics to be covered include "Management of COPD," by Fernando Martinez, M.D.; "New Antibiotics for the 21st Century," by Fred Bode, M.D.; "Pharmacology for Left Ventricular Dysfunction," by Craig Barnette, M.D.; and "Management of Hypertension in the Diabetic Patient," by George Arnoff, M.D.

This meeting has been reviewed and is acceptable for 18.45 prescribed hours and 3.50 elective hours by the American Academy of Family Physicians. AAFP prescribed credit is accepted by the AMA as equivalent to the AMA PRA Category 1. AOA credit toward Category 2-A for 18.45 prescribed hours and 3.50 elective hours is also approved.

For more details, contact the WVAAFP at 776-1178.

Register early for Annual Meeting!

This year's WVSMA Annual Meeting will again take place during the same week as the West Virginia State Fair, so if you wish to stay at The Greenbrier, phone the hotel at 1-800-624-6070 as soon as possible for reservations.

Please turn to page 43 for more details about the meeting or phone the WVSMA at (304) 925-0342.

Medical Savings Accounts

Michael Tanner, Ph.D., director of Health and Welfare Studies for the CATO Institute, addresses the participants at the symposium on *"Free Market Alternatives to Health Care Reform,"* which the WVSMA presented in Charleston on January 12. Other speakers pictured included John Colbertson, president of Walker Aerospace; Duane Parde, director of state legislation for the Council for Affordable Health Insurance; and WVSMA President Dr. James Comerci.

Charleston to host first international health conference on prevention in October

West Virginia has been chosen as the host state for the *First International Conference on Prevention: The Key to Health for Life*, which will convene from October 27-30.

This international conference is being sponsored by the World Health Organization; the Council of Geriatric Cardiology; the Center for the Study of Aging; the Robert C. Byrd Health Sciences Center of WVU; the three medical colleges of West Virginia; the West Virginia Bureau of Public Health; and U.S. Senator Jay Rockefeller. Approximately 2,000 physicians, health and insurance industry professionals, health care providers and businesses from all over the world are expected to attend.

The goal of the conference is to share knowledge of innovative and established prevention and health care promotion programs in hopes of replicating these programs in other parts of the world. This international conference is timely because of efforts to reduce health care costs. Programs of health prevention, health promotion and delayed dependency can save billions of dollars and thousands of work hours.

West Virginia was chosen as the site for this conference because of the crusading efforts of Lawrence J. Frankel. Frankel, who will celebrate his 90th birthday next year, introduced West Virginians to a common sense program called *"Preventicare"* more than three decades ago. This program is now recognized both nationally and internationally.

At the conference, experts from the United States, Australia, Germany, England, France, Finland, Canada, and many other countries will address high profile prevention and health promotion issues. Invited guest speakers include First Lady Hillary Clinton; Surgeon General of the United States Jocelyn Elders; Secretary of Health and Human Services Donna Shalala; Public Health Service Director Phillip Lee, M.D.; World Health Organization Liaison Hana Hermanova, M.D.; Senators Robert Byrd and Jay Rockefeller; as well as physicians, health care professionals, and providers distinguished in the field of prevention and health care promotion.

Early registration for the conference is suggested. For further information, contact the First International Conference Committee, 10 Hale Street, Charleston, WV 25301, (304) 342-1200; or the Charleston Chamber of Commerce at (304) 345-0770.

Nominations being taken for Country Doctor Award

Staff Care, Inc., a temporary physician staffing firm located in Irving, Texas, is again accepting nominations for the 1994-95 Country Doctor of the Year.

Last year was the first year this organization had awarded this honor to a rural physician, and the ceremony where the award was given to Dr. John Harlan Hayes Jr. in Vivian, La., gained national attention.

To obtain a nomination form, call Staff Care, Inc. at 1-800-685-2272.

New study compares tympanometry, reflectometry

A recently published study in *Contemporary Pediatrics* provides some significant findings regarding the diagnosis of otitis media with effusion during the first 24 months of life.

The study offers a comparison of the two methods and concludes that reflectometry is particularly more accurate in the critical age group of 3 to 24 months.

A reprint of this study, as well as a free loan copy of a video on sonar and microprocessor technology, is available by contacting ENT Medical Devices, Inc. at 1-800-325-3015.

Wyeth-Ayerst offering new patient materials

A new video entitled *"Hysterectomy Kit,"* and a new booklet, *"What a Man Should Know About Menopause,"* are now available from Wyeth-Ayerst sales representatives.

In addition to these materials on menopause, the company is offering *Seasons*, a magazine for Premarin patients; and the *"Life After 45"* series, a comprehensive six-part program about health issues affecting middle-aged women.

Continuing Medical Education

Listed on this page are some of the upcoming CME programs which will be held in the state. Unless otherwise noted, the events are presented at the location under which they appear.

If you would like to have the CME programs offered by your institution or association for physicians printed in the *Journal* or obtain more details about the meetings listed, please contact Nancy Hill, managing editor, at 925-0342.

Marshall University School of Medicine - Huntington

March 22
"7th Annual Research Day," 8 a.m.

Raleigh County Medical Society - Beckley

February 22
"Anti-Microbial Resistance," Prosad V. Devabhaktuni, M.D., 6:30 p.m., Black Knight Country Club

February 24
"Update on Fibromyalgia," Stephen R. Cirelli, M.D., 6:30 p.m., Black Knight Country Club

Robert C. Byrd Health Sciences Center of WVU - Charleston

March 3
"Teleconference on the Pitfalls in the Initial Evaluation of the Trauma Patient," noon - 1 p.m., HSC and satellite locations

March 3-4
"Pediatric Advanced Life Support," 8 a.m. - 5:30 p.m., CAMC Education and Training Center

March 15
"Management of a Neck Mass" (sponsored by The Eye and Ear Clinic of Charleston and the Dept. of Surgery), Mark K. Wax, M.D., 4th Floor Faculty Lounge

March 17
"Teleconference on Abdominal Distention and Vomiting in the Newborn," noon - 1 p.m., HSC and satellite locations

April 19
"Mini and Maxi Flaps" (sponsored by The Eye and Ear Clinic of Charleston and the Dept. of Surgery), Ted Jackson, M.D., 4th Floor Faculty Lounge

Robert C. Byrd Health Sciences Center of WVU - Morgantown

March 18-19
"AIDS in West Virginia" (sponsored by the WVU Dept. of Medicine, Section of Infectious Disease), Charleston House Holiday Inn, Charleston

March 25-26
"Spring Meeting of the West Virginia Chapter of the American Academy of Pediatrics" (sponsored by the WVAAP and the WVU Dept. of Pediatrics), Morgantown

West Virginia State Medical Association - Charleston

March 12
Level I Loss Prevention Program - Huntington

March 26
Marbury vs. Madison Loss Prevention Program - Wheeling

Outreach Programs

Key to Sponsors

★ *Robert C. Byrd Health Sciences Center of WVU, Morgantown*

☐ *CAMC/Robert C. Byrd Health Sciences Center of WVU, Charleston*

Gassaway ☐ Braxton County Memorial Hospital, Feb. 23, 6:30 p.m., TBA, Steven Jubelirer, M.D.

Logan ☐ Logan General Hospital, Mar. 18, 11:45 a.m., "New Treatment for Fibrillation/Flutter," Ronald J. McCowan, M.D.

Madison ☐ Boone Memorial Hospital, March 8, 6:30 p.m., "New Treatment for Fibrillation/Flutter," Ronald J. McCowan, M.D.

Montgomery ☐ Montgomery General Hospital, March 2, 12:30 p.m., "New Treatment for Fibrillation/Flutter," Ronald J. McCowan, M.D.

Oak Hill ☐ Plateau Medical Center, March 22, 6:30 p.m., "New Treatment for Fibrillation/Flutter," Ronald J. McCowan, M.D.

Parkersburg ★ Camden-Clark Memorial Hospital, Feb. 23, 7 a.m., "Return to Work for the Injured Worker: Principles and Caveats"

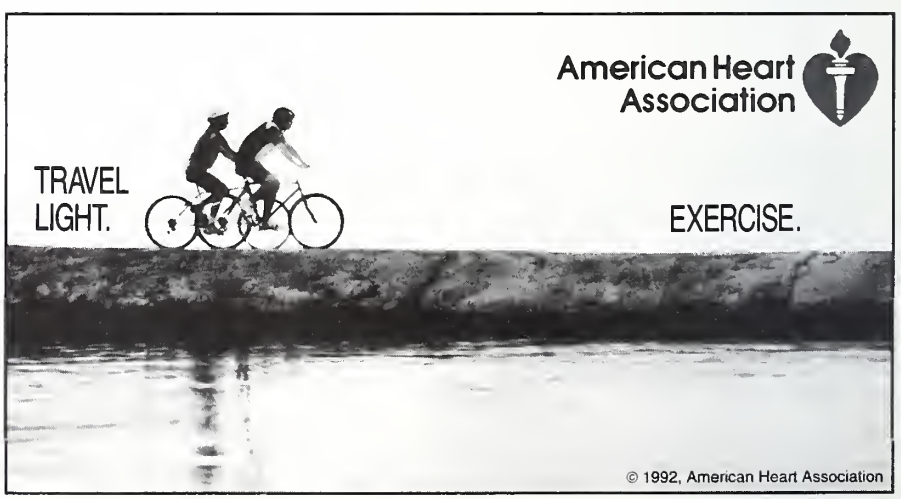
★ Camden-Clark Memorial Hospital, Mar. 16, 7 a.m., "Management of Obesity"

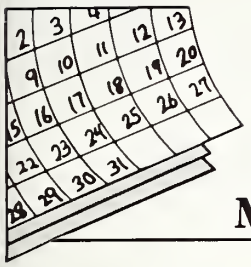
★ Camden-Clark Memorial Hospital, Mar. 23, 7 a.m., "Some New or Rediscovered Bacterial Pathogens"

Philippi ★ Broaddus Hospital, Mar. 3, 7 p.m., "AIDS"

Point Pleasant ☐ Pleasant Valley Hospital, Feb. 24, noon, "Appendicitis," A. Margarita Torres, M.D.

Spencer ☐ Roane General Hospital, March 15, 12:15 p.m., "Disease of the Larynx," James Spencer, M.D.





Medical Meetings

March

1-2–Good Medicine is Good Business (sponsored by the National Business Coalition and the National Association of Managed Care Physicians), Reston, Va.

2-3–Challenge of the 90s: Ethical Issues in Medicine (sponsored by Eastern Virginia Medical School), Norfolk, Va.

4-5–The 37th Annual Postgraduate Symposium in Ophthalmology: Diagnostic Pathology (sponsored by Ohio State University), Columbus

4-9–American Academy of Allergy and Immunology, Anaheim, Calif.

5-10–21st Annual Critical Care Medicine Course (sponsored by The University of Oklahoma Health Sciences Center), Oklahoma City, Okla.

5-12–Update in Clinical Medicine (sponsored by The George Washington University Medical Center), Vail, Colo.

10-13–Clinical Electrocardiography: Basic Concepts and Interpretation - 14th Edition (sponsored by Eastern Virginia Medical School), McLean, Va.

12–Medical Management of the Atherosclerosis Plague (sponsored by The George Washington Medical Center), Atlanta

13-17–American College of Cardiology, Atlanta

18–Ultrasound in Abdominal Surgery (sponsored by The George Washington University Medical Center), Washington, D.C.

20-25–3rd Annual Cardiovascular Disease Conference: The High-Risk Patient: An Interspecialty Approach (sponsored by Ohio State University), Snowmass-Aspen, Colo.

23-26–Toward an Electronic Patient Record '94: Tenth International Symposium on the Creation of Electronic Health Records and Sixth Global Congress on Patient Cards (sponsored by Medical Records Institute), Washington, D.C.

24-25–West Virginia Urological Society's Annual Spring Meeting, Morgantown

April

5-9–20th Annual Meeting of the Society for Biomaterials, Boston

9–Psychiatry Clinical Update: The Treatment Resistant Patient: Thick Chart Syndrome (sponsored by Ohio State University), Columbus

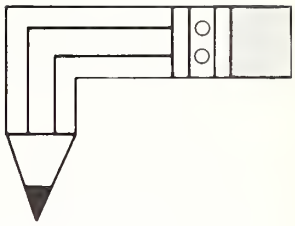
10-11–Planning Conference on Management Requirements for a National Implant Data System (sponsored by the Society for Biomaterials), Hyannis, Mass.

16–Gastroenterology Update (sponsored by Ohio State University), Columbus

For More Information . . .

Contact the Journal at (304) 925-0342.

Poetry Corner



Make-Believe

The make-believe which children play
In innocence of early life,
Before the grown-up problems start,
Entices me to flee the strife
Which makes the days of later years
So full of worry, pain and tears;

Go back and play some make-believe;
Be like a care-free child once more;
Enjoy some days of hope-filled dreams;
Some days of youth and health restore;
Then look ahead to later years
While being free of rootless fears.

But in this life of grown-up truth
There is no time for make-believe;
For in this life's reality
We have to take what we receive,
And live our days of "golden years"
The best we can among our peers.

E. Leon Linger, M.D.

Please address your submissions for Poetry Corner to Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

"WHICH ONE OF THEM IS IT THAT WILL KILL YOU?... POLYSATURATED OR POLYUNSATURATED?"

Bureau of Public Health News

This page of material is submitted and paid for by the Bureau of Public Health.

Agencies submit plans for health reform

According to a new "white paper" released by several public health agencies in West Virginia, the role and functions of public health must be clearly defined and should serve as the base for a reformed health care delivery system.

The paper, "Public Health in the Reformed State Health Care System," was developed by representatives from the West Virginia Association of Local Health Departments, the West Virginia Bureau of Public Health and the West Virginia Public Health Association, Inc., in an effort to support positive changes in the state's health care system. It states that population-based prevention services, protection of the public's health through enforcement of policies, and promotion of individual and community health behavior changes are keys to long-term health improvement in the state and nation.

This white paper represents a consensus on the mission, roles, structure, funding and transition efforts for public health agencies at local, regional and state levels in West Virginia.

"We have the chance to make a real difference to improve the access and delivery of quality health care for the people of West Virginia," said Earl Burgess, president of the West Virginia Association of Local Health Departments. "But to be successful, we must be aggressive and innovative, and we feel that many of the proposals in this white paper do just that."

Some of the proposals call for changes in the focus of public health, and Bureau of Public Health Commissioner William T. Wallace, Jr., M.D., M.P.H., says many of those changes are a revisit of the foundation of public health values. "Health care has too often become big business, and many public health agencies have joined in the competition," said Wallace. "We need to look at fulfilling the true missions of public health as they are meant to be and then at filling in the gaps in health care delivery where they exist, rather than duplicating available services."

"We feel we've learned a lot, and accomplished a lot, just by coming together to talk about these issues," said Chris Gordon, president of the West Virginia Public Health Association. "We know we haven't always seen eye to eye on every problem or solution, but we do agree that public health must play a key role in health care reform, and we feel the proposals in this paper are a good start to improving health care for West Virginians."

This document paper has been presented to Governor Gaston Caperton and to state lawmakers in preparation for the upcoming legislative session. If West Virginia is a leader in health reform it's more likely to be awarded federal funding for developing various parts of any reform package.

State public health official named leadership scholar

Nancy J. Tolliver, R.N., M.S.I.R., deputy commissioner of the West Virginia Bureau of Public Health, has been selected to serve as a Scholar in the third annual national Public Health Leadership Institute. Ms. Tolliver joins an elite group of the top 50 public health leaders in the Institute's year-long program.

The purpose of the Institute is to strengthen America's public health system by enhancing the leadership capacities of state public health officials. Launched in July 1991, the Institute is funded by the Centers for Disease Control and Prevention (CDC) and is conducted by the CDC and the Western Consortium for Public Health, which includes the University of California at Berkeley, the University of California at Los Angeles and San Diego University.

AIDS programs to target youth

The West Virginia Bureau of Public Health AIDS Program is joining national efforts to increase AIDS education and prevention among young people. As the U.S. Centers for Disease Control and Prevention (CDC) launches a new campaign targeting people age 25 and younger, the state AIDS Program is initiating pilot youth programs in Kanawha and Cabell counties.

The programs will go beyond providing basic HIV/AIDS education. Staff at agencies serving youth will be assisted in promoting risk reduction activities, including self-esteem building, decision making and negotiation skills. Cynthia Rinaldi, an educator with the AIDS program, said West Virginia's young people are at increased risk of HIV infection because many don't perceive themselves at danger and continue risky behaviors.

"Look at the state's rates for teen pregnancy and sexually transmitted diseases, and it's obvious that many teens are having sex without using condoms," Rinaldi commented. "It's very difficult to convince 16-year-olds, who often believe they're invincible, that one incidence of unprotected sex might put them at risk of dying 10 years later."

AIDS Program statistics indicate that the incidence of HIV among the state's youth is increasing. Since 1984, 77 of 389 reported AIDS cases have occurred in people in their twenties. HIV often has an incubation period of 10 years or more, so many of these people were probably infected as teens. Since 1989, 17 of the 471 West Virginians who have tested positive for HIV were between the ages of 13 and 19. State Epidemiologist Loretta Haddy estimates there are between 2,000 and 4,000 West Virginians who are unaware they are HIV infected because they have never been tested.

The West Virginia AIDS Program offers many education and prevention resources, including videotapes loaned to the public free of charge. For more details, phone the AIDS Program at (304) 558-2950 or 1-800-642-8244.

West Virginia Chapter - American College of Surgeons

Annual Spring Meeting

May 5,6, & 7, 1994

The Greenbrier
White Sulphur Springs, West Virginia

Guest Speakers:

Dr. David C. Sabiston, Jr., Professor and Chairman, Department of Surgery Duke University Medical Center, May 5 at 11:45 a.m.-*"Major Operations in Surgical History"* and May 6 at 11:15 a.m.-*"Surgery of the Coronary Circulation, 1994"*

Dr. Vaughan Starnes, Chairman, Department of Surgery and Director of Cardiopulmonary Transplantation, University of Southern California, May 5 at 10:45 a.m.-*"The Ross Procedure for Aortic Valve Disease"* and May 6 at 10:45 a.m.-*"Current Indications for Lung Transplantation"*

Jane Rothrock, R.N., Ph.D., President - Association of Operating Room Nurses, May 6 at 10:15 a.m.-*"The RN as First Assistant"*

Speakers from the Southwestern Pennsylvania Chapter, the West Virginia Chapter and residents from WV training programs will complete the program. Golf tournament and reception on Friday. 10.5 hours CME. For room reservations, call *The Greenbrier* at 800-624-6070. For information, call Sharon Bartholomew at 598-2802.

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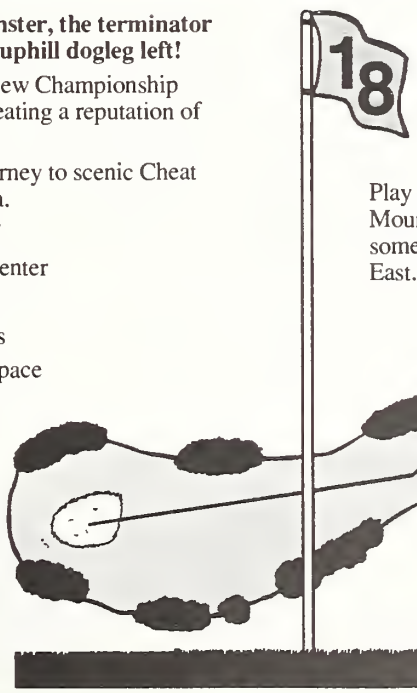

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ROBERT C. BYRD HEALTH SCIENCES CENTER
OF WEST VIRGINIA UNIVERSITY

Compiled from material furnished by the Robert C. Byrd Health Sciences Center of West Virginia University, Communications Division, Morgantown

Brazilian surgeon introduces new endoscopic equipment

WVU surgeons were recently shown the newest instruments in endoscopic surgery by Dr. Marco A. Correa, who is on the staff of the Catholic University Hospital's Department of Plastic Surgery in Porto Alegre, Brazil.

Dr. Correa demonstrated the tomoscope, a new instrument he invented, which is very promising for use in trauma patients because it provides the surgeon a well-lit, hollow space to perform operative procedures.

Dr. Correa worked with Dr. Julio Hochberg, associate professor of reconstructive plastic surgery, on developing uses of these specially designed scopes, which are inserted through minimal incisions in the body. The scopes, now being employed in reconstructive procedures such as breast reduction, allow surgeons to magnify unclear images on a monitor.

According to Dr. Hochberg, these scopes will simplify many surgical procedures and diminish much of the cutting and scarring. "Instead of cutting," he says, "we have begun using a 'puncture elevator' which lifts the breast tissue and allows us to reduce it endoscopically."

Ulcers can be treated with antibiotics

Gaskins

Doctors at WVU have recently started to treat their patients who are suffering from certain kinds of peptic ulcers with vigorous doses of antibiotics.

This is a radical departure from the traditional methods of controlling diet and lifestyle, and reducing stomach acid. And, for many patients, it appears to be much more effective at eliminating recurrent ulcers.

In the early 1980s, Australian researchers opened the door to new ways of dealing with ulcers. They demonstrated that over 90 percent of people with duodenal ulcers, and 70 percent of those with gastric ulcers, had the same strain of bacteria in their stomachs.

"If we use the standard treatment, which centers around medication and a diet to reduce stomach acid, a large number of people will have recurrence of their ulcers because the bacteria are still there," Dr. Ronald D. Gaskins, gastroenterology section chief said. "If we kill these bacteria with antibiotics, most people show no recurrence of ulcers."

Dr. Gaskins points out that not everyone with ulcers is a candidate for antibiotic treatment. There is no benefit in antibiotic treatment for people whose ulcers are caused by the use of aspirin or ibuprofen, or for those who have ulcer symptoms without having an ulcer. "For these people, the standard treatment is still the best: using antacids, drugs called histamine receptor blockers, and diet control," he added.

Klingberg Center awarded federal grant

WVU's W. G. Klingberg Center for Child Development has received a $800,000 grant from the U.S. Office of Maternal and Child Health to help care for children in West Virginia with learning disabilities, mentally and physically handicapping conditions, and behavioral and developmental problems.

The four-year grant is designed to train families and professionals in family-centered care. Trainees will come from the State of West Virginia's Children with Special Health Care Needs clinics (formerly the Department of Handicapped Children's Services).

During the first two years of the grant, training will take place at clinics in the Morgantown area, and then it will be taken statewide.

Faculty members make presentations

Vale

Waxman

Dr. Janie R. Vale, assistant professor of occupational medicine, presented two sessions at the Back Pain '93 Conference in Boston. Her sessions described the effect of the Americans with Disabilities Act on treatment and reimbursement for workers with injured backs, and how to access government-mandated health care.

Another faculty member, Dr. Mark K. Wax, assistant professor of otolaryngology, presented three papers at the 87th Annual Scientific Assembly of the Southern Medical Association in New Orleans. His co-authors included: Mike Hurst, M.D., D.D.S., assistant professor of otolaryngology; Gerald Nieusma, D.D.S., associate professor of oral and maxillofacial surgery; and Dr. Orlando Ortiz, assistant professor of radiology.

In addition, Dr. Wax also presented a poster he co-authored, and Dr. Rohit Bawa, chief resident, presented a paper entitled "Anaplastic Thyroid Carcinoma" and two posters.

In Memoriam

Eric Humphries, Ph.D., 48, died December 11. Dr. Humphries was a professor in the Department of Microbiology/Immunology and scientific director of the Mary Babb Randolph Cancer Center.

"It's tragic to lose Eric at such a young age," says Fred Butcher, Ph.D., director of the Cancer Center. "We are going to miss his positive and optimistic outlook. It will be a tremendous challenge to continue the standard of success he established."

Dr. Humphries is survived by his wife, Caroline, and his four children.

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Webster's Ninth New Collegiate Dictionary

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Marshall University School of Medicine

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington.

HUD releases $4.5 million for Rural Health Center

U.S. Senator Robert C. Byrd has announced that the Department of Housing and Urban Development has released $4.5 million to establish the Southern West Virginia Center for Rural Health at Marshall.

The facility will serve as a base for rural-oriented medical treatment, teaching, research and support services, according to Dean Dr. Charles H. McKown Jr. Faculty will help provide or coordinate services not otherwise available in the counties of Cabell, Wayne, Lincoln, Mingo, Mason, Roane, Boone, Putnam, Jackson, McDowell, Wyoming and Logan.

Providing approximately 27,500 gross square feet of space, the center will house:

* Innovative and comprehensive health programs;
* Special services and educational programs for students and health professionals;
* An improved library and learning resources center; and
* The Marshall Rural Health Research Institute.

"Basing these programs at a central site will allow us to use our resources more efficiently, as well as provide a critical mass for focusing on rural health needs," Dr. McKown said.

Major projects of the Rural Health Research Institute include determining more effective methods to present cancer prevention and early detection information to rural populations, developing ways to improve care for elderly people in rural areas, and measuring the effectiveness of programs that tailor medical education to the needs of rural areas. The institute also is designed to provide support services to assist rural providers who want to conduct research projects.

Student health program brings parents to school

In Lincoln County, health providers and school officials are collaborating on an intensive program designed to increase both the number and the impact of early periodic screenings, and diagnostic and testing program evaluations.

The school health program restores a missing link in the student health process: families. The program, which is apparently the only one of its kind in the nation, invites parents and siblings to catch the school bus on clinic day and go to school with students.

"It takes parents to solve the problems in health and education, so instead of sending students home with a generic consent form, we're asking the parents to come in with them," said Gerry D. Stover, executive director of the Lincoln Primary Care Center and a volunteer faculty member at Marshall.

Parents can talk directly with providers about the exam and their child's health. They also can accompany their children through the school day, do volunteer work, and participate in parenting classes that emphasize parental involvement and building self-esteem. The program reaches all Lincoln County elementary schools and Guyan Valley High School.

Dr. Robert B. Walker, chairman of family and community health at Marshall, said the program fills an important gap.

"The beauty of this program is that it gets parents together with the provider and the child," Dr. Walker explained. "That has been a big hole in the system -- you can screen children at school, but then how do you assure follow-through with a 7-year-old? Our experimental concept has been quite successful, with more than 90 parents participating since the program began last fall.

"This is a true joint effort of the Board of Education, the Lincoln Primary Care Center and Marshall. Participants in the screenings include Lincoln County school nurse Pam Dice (who also is seeking her master's degree through Marshall's family nurse practitioner program), LPCC physician assistant Gary Culver and medical students. Social workers from the LPCC and Prestera Mental Health Services also contribute to the program."

NIH investigator featured speaker for 7th Research Day

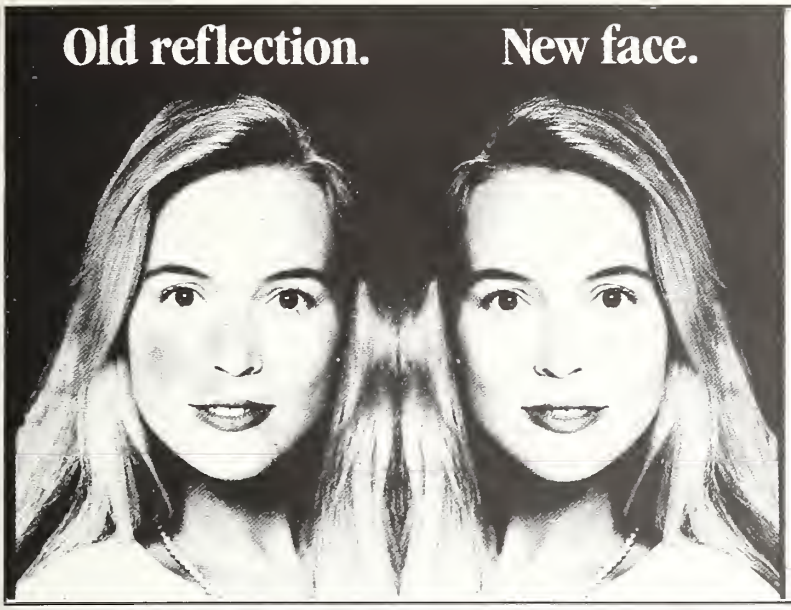
Interested health professionals are invited to attend the School of Medicine's Seventh Annual Research Day on March 22 at the Holiday Inn Gateway Convention Center in Barboursville.

Students, residents and faculty will offer research presentations and clinical case presentations throughout the day. Activities will begin at 8 a.m. and will conclude with an awards presentation and reception ending at 6 p.m. This year's keynote speaker will be Abner Louis Notkins, M.D., director of the intramural research program and chief of the Laboratory of Oral Medicine at the National Institute of Dental Research.

For the Research Day Opening Lecture, Dr. Notkins will speak on "Polyreactive Antibody Molecules and Natural Immunity." This program will begin at 7 p.m. on March 21 in the Marshall Fine Arts Building, located east of Hal Greer Boulevard on Fifth Avenue.

Dr. Notkins will also lecture on "The Bethesda Experiment" for the Research Day luncheon which will take place on March 22 at noon at the Gallery. His research interests lie in the etiology, pathogenesis and molecular biology of viral, autoimmune and endocrine diseases with emphasis on diabetes mellitus. He has had approximately 300 scientific papers published, and has edited four books.

To obtain more information or register, call 696-7019.



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12 Fairland Drive
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Kenneth Parker, M.D.
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Society News

McDowell

At the Society's December meeting, members continued their discussion about whether they should disband as a component society.

Dr. Herland, president of the McDowell County Medical Society, mentioned that in November, a motion to disband had failed to carry, with three members voting in favor and five members abstaining. Dr. Kuppusarni then made a motion to disband the society and it was seconded by Dr. Vega. Only two members voted for the motion, so it failed to pass for lack of a majority. The question of officers for 1994 was then raised by Dr. Herland and the members decided to maintain their present leaders.

At their January meeting, the members discussed Dr. Herland's proposal to form a speakers bureau. Members were also given a treasurer's report by Dr. Michaelis.

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Obituaries

William W. Guthrie, M.D.

Dr. William W. Guthrie, 73, of Montreat, N.C., formerly of Huntington, died November 24 at home.

Dr. Guthrie was retired from Huntington Physicians and was a former administrator at Guthrie Memorial Hospital. He was a graduate of the University of Pennsylvania and the University of Maryland.

An Army veteran of World War II, Dr. Guthrie was a member of Black Mountain Presbyterian Church and a former member and elder of First Presbyterian Church in Huntington. In addition to being a member of the WVSMA, Dr. Guthrie was a member of the AMA and the Cabell County Medical Society.

Surviving: wife, Mary Lou Guthrie; sons, William of Atlanta, Dr. Robert of Columbus, Ohio, and Dr. David of Chambersburg, Pa.; mother, Carolyn Guthrie of Minneapolis; sister, Margaret Smith of Minneapolis; and eight grandchildren.

Memorials may be made to the Black Mountain Presbyterian Church Building Fund or Swannanoe Valley (N.C.) Habitat.

Kenneth M. Harman, M.D.

Dr. Kenneth McKee Harman, 45, of Charleston died November 26 at Charleston Care Center after a long illness.

Dr. Harman was a partner of Charleston Gastroenterology Associates and a clinical associate professor of medicine at the Robert C. Byrd Health Sciences Center of WVU, Charleston Division. He attended Elizabeth Memorial Church in South Hills.

A 15-year resident of Charleston and a Navy medical veteran, Dr. Harman was a graduate of the West Virginia University School of Medicine. He interned at the Naval Medical Center in San Diego, completed a residency at CAMC, and then served a fellowship at Duke University Medical Center.

Dr. Harman had been a member of the WVSMA since 1983 and was a member of the Kanawha County Medical Society.

Surviving: wife, Patricia Griffith Harman; son, Robert of Charleston; daughter, Kara Elizabeth Harman of Charleston; parents, Quinten V. and Mary Virginia Sinnett Harman of Mozer; and sisters, Barbara Rohrbaugh of Maysville and Faye Hedrick of Petersburg.

Memorial donations may be made to the CAMC Foundation, 3100 MacCorkle Avenue, Charleston, W.Va. 25304, c/o Dr. Bert Bradford.

Frederick V. Lilly, M.D.

Dr. Frederick Vivan Lilly, 78, of Beckley died February 2 in a Princeton hospital following a short illness.

Dr. Lilly was born in Glen Morgan and was a graduate of the West Virginia University School of Medicine. He was a World War II veteran, having served his internship at the U.S. Navy Hospital in Bethesda, Md., as a medical officer.

Dr. Lilly was in general practice in Rainelle and Beckley, and had been an ear, nose and throat specialist in Beckley since 1955. In addition to being a member of the WVSMA, Dr. Lilly was a member of the AMA and the American Board of Otolaryngology. He was certified by the American Board of Otolaryngology.

A staff member at Beckley Appalachian Regional Hospital, Beckley Hospital and Raleigh General Hospital, Dr. Lilly was a past president of the Raleigh County Medical Society and of the medical staff at Raleigh General Hospital. He was a past member of the board of directors at Black Knight Country Club, and was a past president and chairman of the board at First National Bank in Beckley.

Survivors include his wife, Lena Lee Pollastrini Lilly; three sons, Fred Lilly II of McLean, Va., Eric Lilly of Greensboro, N.C., and Thomas Lilly of Ft. Lauderdale, Fla.; a daughter, Sandra Lee Fitzmaurice of Louisville, Ky.; two brothers, Ira Lilly of Jumping Branch and Keith Lilly of Dale City, Va.; a sister, Shirley Lester of Jumping Branch; and five grandchildren, Frederick V. Lilly III, Tricia Lilly, Preston B. Lilly, E. Van Lilly and Scott Fitzmaurice.

Memorials may be made to the WVU School of Medicine in Morgantown.

Jack Pushkin, M.D.

Dr. Jack Pushkin, former chief of orthopedics at Charleston Area Medical Center, died December 15 at home of cancer. He was 61.

Born in Charleston, Dr. Pushkin was a 1963 graduate of the West Virginia University School of Medicine. He interned at the University of Minnesota Hospital and then completed a residency in orthopedic surgery at the WVU Medical Center from 1964-68.

During the 1973 Arab-Israeli war, Dr. Pushkin flew to Israel, where he volunteered as a battlefield surgeon, working sometimes two or three days on end trying to hold together bodies and preserve lives.

Dr. Pushkin discovered he had cancer of the liver in 1991. He underwent 16 hours of surgery in Pittsburgh to replace his liver, remove his spleen, pancreas, transverse colon and three-fourths of his stomach. After staying in the hospital three months, he came home and gradually regained his strength.

A member of the WVSMA since 1969, Dr. Pushkin was also a member of the American Academy of Orthopedics, Eastern Orthopedics Association and Orthopedic Surgical Trauma Association. He was a veteran of the Korean War and a member of B'Nai Jacob Synagogue and B'Nai Brith.

Surviving: wife, Pamela Maynor Pushkin; sons, David of New York City, Michael of Morgantown and Joshua at home; daughters, Lesli Sterling of Los Angeles and Leah Pushkin at home; brother, Dr. Martin Pushkin of Morgantown.

Memorial contributions can be made to the Juda B. Pushkin Memorial Foundation, care of Cookie Glasser, Suite 311, 815 Quarrier St., Charleston, W.Va. 25301 or B'Nai Synagogue, Charleston.

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Front Cover

The view from Silver Creek Ski Resort in Pocahontas County. Photo courtesy of *David Fattaleh,* West Virginia Division of Tourism and Parks.

SPECIAL SECTION

Mid-Winter Clinical Conference

Highlights of the West Virginia State Medical Association's
1994 Mid-Winter Seminars and Scientific Conferences

January 20-23, 1994

Lakeview Resort and Conference Center
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We thank the participants in the WVSMA's 1994 Mid-Winter Seminars and Scientific Conferences for their support of this program. Your commitment strengthens the Association and is vital to its continuing success.

Robert Hall, Ph.D., professor of philosophy and sociology at West Virginia State College, listens attentively to a participant's comments during his presentation on "Physician-Assisted Suicide."

Dr. Alvin Moss of WVU gestures with his hand as he begins his lecture, "Health Care Decision Making in West Virginia: Effect of the New Statutes," for the First Scientific Session on "Moving Points in Medicine." This session was jointly sponsored by the West Virginia Chapter of the American College of Physicians and the WVSMA.

Sometimes you just can't take health care reform so seriously . . . Panelists Dr. James Borland Jr., treasurer of the American College of Physicians; Dr. Skip Turner, a past president of the WVSMA; and WVSMA President Dr. James Comerci enjoy the humorous remarks of a colleague during the Physician/Public Session.

Dr. Norman Taylor uses his pencil for extra emphasis when asking a question at the Physician/Public Session.

The proud recipients of this year's Laureate Awards from the ACP were Dr. Maurice Mufson of Marshall University and Dr. Rashida Khakoo of West Virginia University.

Guests such as Nancie Divvens, WVSMA associate executive director, displayed their musical talents by singing along with the laser karaoke machine operated by Dr. Rano Bofill in conjunction with the Dr. Jun Neri show. Nancie's version of "Crazy" was a real crowd pleaser.

Dr. Daniel Foster steps out in style during his rendition of "Hey, Good Lookin'."

Veteran performer Dr. Jun Neri of Princeton presented a fabulous evening of entertainment at the conference.

WVSMA Executive Director George Rider and WVSMA President Dr. James Comerci teamed up to sing "On the Road Again."

Their mothers have nothing to worry about . . . Dr. Norman Taylor, WVSMA Council Chairman Dr. Robert Pulliam and WVSMA General Counsel Michele Grinberg sang "Mommas Don't Let Your Babies Grow Up to Be Cowboys."

David Bailey of the MU Office of CME, and his wife, Pam, chose the romantic Stevie Wonder tune, "I Just Called to Say I Love You," for their laser karaoke number.

While her husband, Dr. Rano Bofill, operated the laser karaoke machine, Judy Bofill sang a duet with Dick Ledford of I. C. Systems, Inc.

The more the merrier . . . Dr. Lewis Cook (left), Gary and Tamara Lively, and Michele Sull and her financé Michael Myers made their musical debut with WVSMA President Dr. James Comerci.

Sporting his camera, Dr. Edward Pinney enjoyed performing for the audience.

Belting it out like Sinatra, Dr. Kurt Palazzo selected favorites of "Old Blue Eyes" whenever he took a turn at the microphone during the evening.

Dr. Alan Ducatman comments about one of his slides during his lecture for the Symposium on Environmental Medicine and Patient Communication, which was co-sponsored by the WVSMA and the National Institute for Chemical Studies in Charleston.

AMA Trustee Dr. Randolph Smoak Jr. (second from left) responds to a participant's question about the Clinton health care plan during the Lunch and Learn at the conference. The other panelists for this event included Dr. Robert D'Alessandri, vice president for health sciences and dean of the WVU School of Medicine; WVSMA President Dr. James Comerci; and WVSMA Council Chairman Dr. Robert Pulliam.

Dr. Derrick Latos, a past-president of the WVSMA, directs a question to a speaker during the First Scientific Session.

Mark Wright, president of the WVSMA Medical Student Section from 1993-94, addressed the students about a variety of issues at their annual meeting.

Representatives from New Century Imaging, Inc. demonstrate a computer system for Dr. Richard Hayes of Charleston.

Two of the faithful exhibitors who braved the snowy weather to attend the conference were Ann Hammack and Teresa Ansell of Saint Francis Hospital in Charleston.

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Practice satisfaction among young West Virginia family physicians

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Abstract

Young family physicians, those in their first five years of practice, were surveyed to determine their satisfaction regarding various aspects of their practices. A total of 67% of the physicians surveyed responded and the results indicated that most family doctors located in communities where there was a perceived need for their specialty. The survey also showed that two of the most important factors necessary to attract and retain family doctors in rural practice are enhanced third-party reimbursement and the availability of other family physicians to share call. This study underscores the necessity to know and understand the sentiments of West Virginia family physicians in order to attract more newly-trained doctors into rural practice.

Introduction

Specialty choice for most physicians is a difficult decision, and family physicians, in particular, have increasing challenges in selecting this field of medicine. Since retaining good family physicians in rural areas of West Virginia is so important, this survey was conducted to understand the motivating forces behind career choices, practice type and location, as well as evaluate the level of satisfaction with practices in this specialty.

Methods

In the spring of 1993, surveys were mailed to 125 family physicians who had entered practice in the past five years. This four-page questionnaire asked each respondent about the size of his/her practice, community population, practice scope, age, sex, marital status, children, night call frequency, and board status.

Satisfaction ratings from 0 - 3 were requested for location, practice scope, call frequency, professional satisfaction, vacation coverage, CME availabilities, cultural activities, family ties and recreational opportunities. In addition, respondents were asked to hypothetically choose a practice location and rate the desirability and importance of various characteristics. Comments were solicited at the end of the questionnaire and ample room was left for comment.

Mailing lists were obtained from AAFP data and they were reviewed to avoid duplication. Anonymity was maintained and results were transferred to a computer spread sheet.

Results

Of the 125 surveys mailed, 84 were returned for a 67% response rate. Out of the total who responded, 72 (86%) were board certified family physicians; 38% were residency trained; 83% were married; and 69% had children. The average age for men responding was 35.4 years and for women was 36.8 years.

A total of 38% of the physicians responding practiced in communities with populations of less than 5,000. One third were solo practitioners, and less than half were in groups of three or more. The clear majority of these physicians were in private practice, i.e. fee for service, with only 5% involved in managed care practice arrangements.

About 85% of all physicians reported their practices as office based, but one out of four did not involve a hospital practice. Only 25% of the physicians surveyed practiced obstetrics, 59% practiced in ICU or CCU settings, and 27% practiced all or part time in emergency departments. Almost one fourth had privileges at more than one hospital.

Only 16% of these family physicians were involved in teaching more than 20% of the time. In addition, one third (33.5%) experienced nightly call, and only 15% have no night call.

For the most part, the responding physicians rated medium to high satisfaction with the characteristics of their practice (Scale 0 - 3). Considerable satisfaction with practice location (2.45) and scope (2.65) were reported. Less satisfying aspects of their practices included characteristics of lifestyle (2.15), availability of non-professional pursuits (2.4), overall enjoyment of life (2.5), and availability of professional coverage (2.25). The lowest satisfaction rating (2.0) was reported for practice income.

When these physicians were asked why they located in their particular setting, a majority stated that community need was the most important factor (2.1). The least attractive feature that led to establishing their practice in a particular location was the economic climate of the state (.85), followed closely by availability (or lack) of cultural amenities (.95). Significant positive factors also included family ties (1.35), contact with friends (1.6), as well as nearby recreational opportunities (1.45), and a location-incentive package (1.4). The needs of a spouse were marginally important (1.15).

Interestingly, most respondents indicated the likelihood to choose a practice in the same area if given the opportunity to do so, and they would favor an area more urban than rural. A significant number of physicians indicated a desire to leave the state and a few expressed a desire for either a more limited or broad-based practice. A few doctors stated they would opt for a larger hospital with more sub-specialists. In addition, more family physicians ranked back-up as a desired option (1.2), and relocation to

a more prosperous area was slightly less important (1.1).

To encourage young family physicians to locate in a rural practice, the respondents suggested a number of factors (Figure 1). The highest rated factor was the desire for more family physicians with which to share call coverage (2.7), followed closely by higher reimbursement (2.55). Loan repayment and salary guarantees were also major factors (2.5 each), as were school opportunities for children (2.45).

Lesser, but still significant factors for encouraging young family physicians to locate in a rural practice, were medical school and residency training rural experience (2.35), the need to improve the malpractice climate (2.25), tertiary medical center contact (2.05), recreational opportunities (2.05), cultural amenities (1.85), and CME opportunities (1.75). Of special interest is the fact that the rural background of a physician (2.05) or that of a spouse (1.95) were perceived as factors with only modest significance.

Discussion

Campos-Outcalt and Senf (1) reported in their study that medical students choose family medicine as a career based on three factors: the greater number of weeks of required family medicine rotation, the proportion of faculty in family medicine, and ownership of the school. Their study also indicated a need to search for other factors of influence.

The results of our investigation reveal that young West Virginia family physicians are basically satisfied with the location and content of their practice. Although not uniformly so, most physicians surveyed would choose the same site over again. The family physicians questioned seemed pleased with their rural locations and lifestyles.

The decision to locate in West Virginia seemed to be related to community need more than any other factor. This was reported as more important than family "roots" or personal friends located in a particular area and is contrary to popular belief.

West Virginia's economic climate is a disincentive for family doctors to locate in this state. In our study, it was the lowest ranked factor that led to the choice of a West Virginia practice and only eight respondents indicated economic climate as an attractive feature.

If given a choice to select criteria for enticing a young physician to locate in a rural practice, the surveyed physicians clearly made two points:

1) The most important factor that would attract more family doctors to a rural practice location is the presence of other family doctors in the area; and
2) Almost as important is the need for greater reimbursement for family physician services.

The survey revealed that family doctors are in West Virginia because of community need more than anything else. "Threats to survival" for these physicians include low third-party reimbursement and the lack of colleagues for cross coverage. One third of the physicians in the survey are on-call every night and it requires an exceptional individual to continue this lifestyle for very long.

During the 1980s, U.S. medical schools experienced a decrease in class sizes (2). Along with this trend came a declining percentage of graduating doctors choosing a career in family medicine, and shortages in family physicians now exist in all parts of the country (3).

Many experts agree there is a need to train and retain competent family physicians. There has also been a reduction in the number of medical school graduates choosing fields other than family medicine (4). As pointed out in the results of this survey, low third-party reimbursement for family physicians is a considerable negative factor in attempting to attract and retain these doctors in West Virginia. Repayment of medical school indebtedness as an influence of career choice has not been born out by the statistics in national surveys (5); however, reimbursement for services once in practice seems to be a strong issue.

Conclusions

This survey indicates how young family physicians in West Virginia would like to make practice in this state more attractive. The two most important factors are third-party reimbursement levels and cooperation with other family physicians in the area. Cultural activities, recreational activities and CME availability were not reported as strong incentives.

The results of this survey demonstrate the need to investigate the requirements of young family physicians in West Virginia in more detail. Other rural states are addressing this subject (6,7). West Virginia family physicians need support and encouragement to facilitate the recruitment of more young family physicians.

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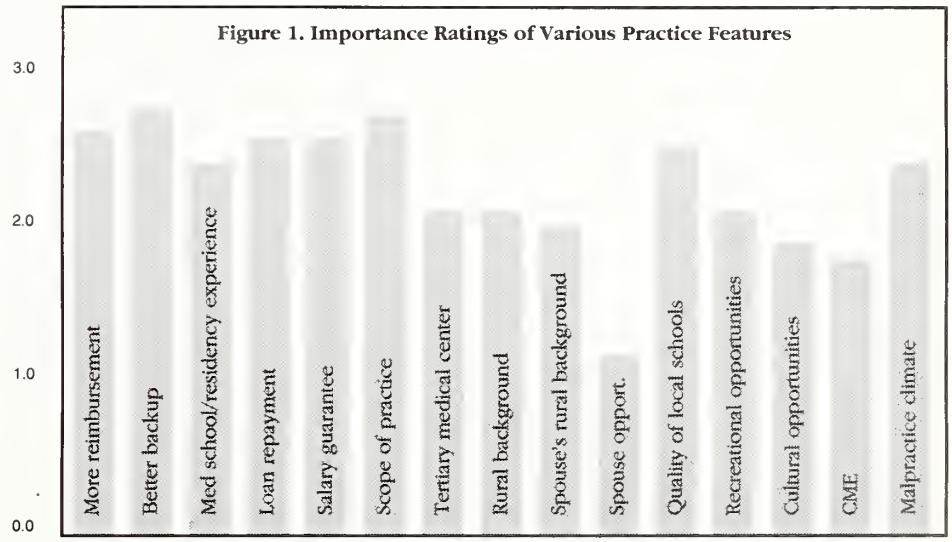
Figure 1. Importance Ratings of Various Practice Features



Intraoperative use of rtPA for subarachnoid hemorrhage

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Abstract

Intraoperative thrombolysis with recombinant tissue plasminogen activator (rtPA) was performed in 15 patients with aneurysmal subarachnoid hemorrhage. All patients had significant basal cistern blood accumulation seen on CT scans preoperatively. The patients underwent surgery within four days of subarachnoid hemorrhage with aneurysm clipping in all patients. Postoperatively, transcranial doppler examinations demonstrated reduction in the development of vasospasm to a greater degree in patients treated with rtPA than a similiar group of patients managed without the rtPA treatment. Eighty percent of patients receiving intracisternal rtPA had fair to good results compared with 78% of a similiar group of patients who underwent surgery shortly after subarachnoid hemorrhage and were not given rtPA. Intracisternal rtPA remains an adjunctive treatment of questionable benefit in the management of patients with aneurysmal subarachnoid hemorrhage.

Introduction

Intracranial aneurysms occur in approximately 5% of the population at large (1) and each year approximately 2%-3% of patients harboring "congenital" berry aneurysms suffer the effects of subarachnoid hemorrhage (2). Without surgical treatment, approximately 25% of patients will have a second subarachnoid hemorrhage within two weeks, and the mortality of ruptured intracranial aneurysms approaches 43% at one week without surgery (3).

Craniotomy with aneurysm clipping is usually the standard treatment for a ruptured aneurysm. Common complications that can arise include cardiac arrhythmias, hypotension, serum inappropriate antidiuretic hormone secretion and pneumonia (4). The frequently observed complication of delayed ischemic neurologic deficit secondary to cerebrovasospasm occurs whether or not surgery is carried out to prevent aneurysm re-rupture (5). In addition, vasospasm will appear in approximately 30%-40% of patients. These individuals will have significant blood in the basilar subarachnoid cisterns (6) (Figure 1), and their extent of vasospasm is measurable by angiogram (Figure 2).

Recently, transcranial doppler (TCD) has been used to demonstrate the degree of arterial velocity increase which is proportional to the severity of vasospasm (7). Vasospasm and its associated delayed ischemic neurologic deficit is likely to be the leading cause of death from subarachnoid hemorrhage (8). Several ancillary therapies for vasospasm have recently been developed including the use of Nimodipine as a prophylaxis. Treatment with hypertensive, hemodilutional hypervolemia has been employed to improve cerebral blood flow during the period of symptomatic vasospasm, which usually lasts from one to two weeks (9). Intraoperative recombinant tissue plasminogen activator (rtPA) has recently been used as a promising therapy to reduce the risk of vasospasm in patients operated on within three days of subarachnoid hemorrhage (10).

This report discusses our results in treating 15 patients with an intraoperative subarachnoid cisternal injection of rtPA immediately following intracranial aneurysm clipping.

Patients and methods

Between July 1, 1991, and December 1, 1992, a total of 33 craniotomies were performed at Charleston Area Medical Center for clipping of intracranial aneurysm. Three craniotomies were done for

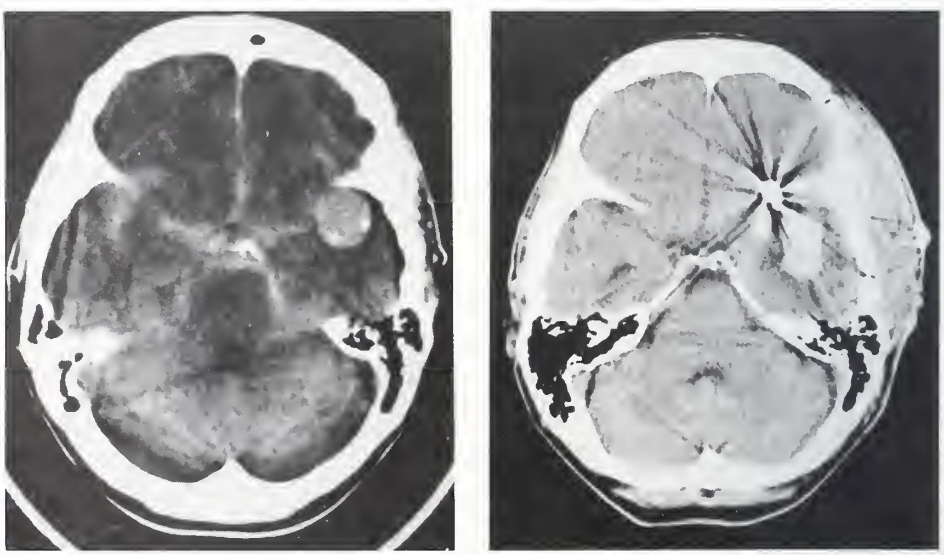

Figure 1. CT scans of patient with giant middle cerebral artery aneurysm and subarachnoid hemorrhage pre-operative (left) and postoperatively (right) showing clearing of subarachnoid blood following installation of rtPA. In addition, the figure at right demonstrates the starburst artifact from the aneurysm clip on the right middle cerebral artery aneurysm.

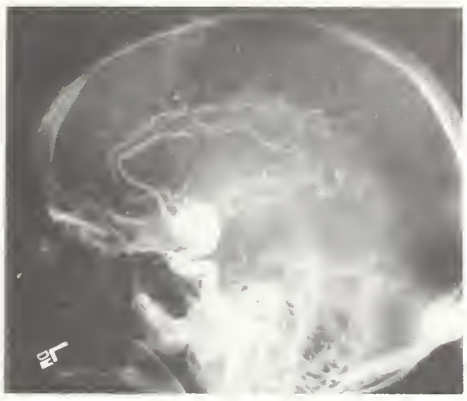

Figure 2. Pre-operative angiogram of patient with giant middle cerebral artery aneurysm seen on CT scan in Figure 1. There is very minimal evidence of vasospasm seen on this pre-operative angiogram.

TABLE 1

PRE-OPERATIVE CLINICAL PATIENT GRADE [HUNT AND HESS (11)]

RTPA Group					No RTPA Group				
Grade	I	II	III	IV	Grade	I	II	III	IV
Number of patients	3	6	4	2	Number of patients	0	6	2	1

TABLE 2

TIMING OF SURGERY FOLLOWING SUBARACHNOID HEMORRHAGE

RTPA Group					No RTPA Group				
Days from bleed	I	II	III	IV	Days from bleed	I	II	III	IV
Number of patients	7	4	3	1	Number of patients	5	1	1	2

TABLE 3

TRANSCRANIAL DOPLER VELOCITY (1-2 WEEKS POST SUBARACHNOID HEMORRHAGE)

RTPA Group			No RTPA Group		
Grade	Normal	Increased	Grade	Normal	Increased
Number of patients	4	8	Number of patients	1	5

TABLE 4

OUTCOMES 6-24 MONTHS POST HEMORRHAGE

RTPA Group					No RTPA Group				
	Good	Fair	Poor	Dead		Good	Fair	Poor	Dead
Number of patients	7	5	1	2	Number of patients	5	2	0	2

incidental aneurysm repair and the remainder following subarachnoid hemorrhage. Transcranial doppler studies were used to assess the degree of cerebral vasospasm present both before and after surgery in these two groups.

After all of the patients underwent CT scanning and cerebral angiography, we performed craniotomy with routine clipping of the intracranial aneurysms. A total of 24 of these patients with ruptured aneurysms underwent craniotomy within four days of subarachnoid hemorrhage. In 15 of these patients, rtPA was used as an adjunct to subarachnoid clot removal at the time of aneurysm clipping.

In patients receiving tissue plasminogen activator, 10 mg. of rtPA was instilled into the intracranial cavity in the region of the ruptured aneurysm and basilar cisterns after clip placement. Following a 15-minute wait, one liter of saline was used to irrigate the operative field and basilar cisterns in order to clear the majority of the rtPA and blood.

Results

The ages of patients in the two groups were similar. Those not receiving rtPA ranged from 33 to 66 years old, while those receiving rtPA ranged between 34 to 65 years old. The group not receiving rtPA consisted of eight women and one man, while there were 12 women and four men who did receive rtPA.

The clinical grade of the patients at the time of surgery was similar (Table 1). The timing of surgery was also similar for both groups, with a majority of patients undergoing surgery within 48 hours of subarachnoid hemorrhage (Table 2).

The results of transcranial doppler studies carried out between one and two weeks post subarachnoid hemorrhage demonstrated normal velocities in 17% of the patients managed without rtPA and in 34% of the patients receiving rtPA (Table 3). Between six and 24 months following craniotomy and treatment, a good to fair result was seen in 77% of the patients not receiving rtPA and in 80% of the patients who received rtPA (Table 4).

Discussion

The presence of subarachnoid blood following aneurysmal rupture is believed to be responsible to a great degree for the appearance of delayed cerebral ischemia from vasospasm (6). Breakdown products of blood including hemoglobin, free radicals and prostaglandins have been felt to play a role in the development of vasospasm (12). Similarly, the volume of blood seen on CT scan after aneurysm rupture is believed to be related to the risk of the development of vasospasm and its complications (13).

Theoretically, early removal of subarachnoid blood should help prevent cerebral vasospasm. Previously, simple intraoperative saline irrigation and dissection of the subarachnoid space have been attempted, but risk/benefit analyses have proved inconclusive (14).

The fibrinolytic substance rtPA has recently been shown to decrease spasm following subarachnoid

hemorrhage in animals (10). Findley and colleagues reported the use of intracisternal rtPA following subarachnoid hemorrhage and early surgery for intracranial aneurysm clipping in 15 patients (15). They demonstrated clearing of subarachnoid blood on CT scans one day after surgery, and only one patient developed symptomatic vasospasm and the only complication of epidural hematoma was reported in this series.

In our study, essentially no postoperative intracranial hemorrhagic complications were seen, and as of August 1993, a total of 121 cases have been reported using rtPA as adjunctive therapy for SAH (15,16,17,18,19,20). A marked reduction in angiographic vasospasm was seen in all of these trials. Similarly, symptomatic vasospasm was seen in only three of these 121 patients. Despite these good results, there has been one series with a 20% mortality (16).

A trend towards reduction in vasospasm as reflected in the normalization of velocities of blood flow seen on transcranial doppler studies was observed in our patients treated with rtPA. However, TCD continued to show evidence of spasm in 50% of the patients in this group one to two weeks post SAH. Outcome was the same in both groups. As expected, poor grade patients of our treatment groups had generally poor outcomes.

Although small, our study suggests there is no clear improvement in patients treated with the intracisternal injection of rtPA following early craniotomy for aneurysm clipping as a treatment for aneurysmal subarachnoid hemorrhage. More study is needed before this therapy will become a standard.

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Tables (tabular listings) and figures (photos, drawings and charts) should be numbered, and the point of reference in the text indicated in parentheses, i.e. (Table 1), (Figure 10). Photos must be unmounted glossy prints in a 5 in. x 7 in. format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be done in solid black on pure white.

All scientific material is reviewed by the Publication Committee and should be sent to The Editor, West Virginia Medical Journal, P.O. Box 4106, Charleston, WV 25364.

Spinal epidural metastases: A common problem for the primary care physician

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Abstract

Spinal metastases are a common complication of cancer that should be managed quickly and aggressively. Most often from lung or breast cancer (or due to lymphoma), they usually seed from blood into vertebrae and extend into the epidural space. The most common presentation is pain and weakness, and the evolution can be rapid with paraplegia within days. Better prognosis is related to slower onset and pretreatment motor status, so spinal metastases are an emergency. Testing includes X-rays, neuroimaging, myelogram/CT and most recently MRI. Treatment is guided by the severity of neurological deficits, whether compression is by soft tissue or bone, and the presence of instability. A soft tissue mass with only mild to moderate deficits can be treated with radiation. Surgery is required for severely affected patients who are deteriorating rapidly with instability and bone in the canal. New approaches and fusion techniques facilitate decompression and stabilization.

Introduction

There are approximately 365,000 cancer deaths per year in the United States. This figure will undoubtedly increase as the geriatric population increases and the life expectancy of cancer patients is prolonged due to improved methods of therapy.

At postmortem exam, up to 70% of the patients who die from cancer will have spinal metastases. It has been estimated that 5% of cancer patients will develop epidural spinal cord compression which translates into about 18,000 cases of symptomatic metastatic epidural spinal cord compression per year.

In one autopsy series, meningeal carcinomatosis occurred with a 4% incidence, primarily due to leukemia, lymphoma, and breast cancer. In another series, there was a 2% incidence of intramedullary metastasis. Prompt and early diagnosis and treatment are crucial to prevent pain and progressive neurologic deficits in such patients (1,2,3).

Bronchogenic carcinoma, carcinoma of the breast, and lymphoma are the most common spinal metastases due to the prevalence of these tumors in the general population (4,5). However, the three cancers with the highest incidence of metastasis are in decreasing order multiple myeloma, prostatic cancer and breast cancer. In approximately 9% of these cases, the primary malignancy is unknown, and in 8% of the cases, spinal cord compression will be the first symptom of cancer. The latent interval from the diagnosis of cancer to the development of spinal metastasis may be as long as 19 years, with breast cancer having the longest latent interval (3,4,6).

The incidence of epidural spinal cord compression involvement of a certain region of the spine is related to the number of vertebrae of that region compared to the total number of vertebrae and the size of the epidural space at that region. The thoracic spine is involved in about 59% of the cases, the lumbar spine in 16%, the cervical spine in 15%, and the sacral spine in the remainder. A large majority of the metastases localize to one or two contiguous vertebral levels. However, 17% of the patients in one series showed evidence of compression of the spinal cord or cauda equina at two or more non-contiguous sites at some time during the course of their disease.

Metastases to the spine and the extradural space occur mainly by hematogenous spread via paravertebral and extradural venous plexi. As a general rule, the vertebral body may be destroyed, but the intervertebral disc is maintained because it is resistant to invasion by tumor. This can be useful in the differential diagnosis between tumor and infection since the latter involves the disc.

Lymphomas enter the spinal canal mainly by direct extension from the adjacent retroperitoneal or mediastinal lymph nodes via the intervertebral foramina (3,4,7,8). Neuroblastomas also enter the epidural space through the intervertebral foramina. The dura matter is an effective barrier to the penetration of tumor cells into the subdural or subarachnoid space, a reason to avoid opening the dura at the time of surgery (2).

Presentation

Pain is the cardinal symptom of spinal tumors and the initial symptom of 96 percent of the cases. Pain precedes other symptoms by five days to two years with a median time of seven weeks. It may be local in the area of spinal involvement, radicular along the dermatome or sclerotome supplied by the root involved, or funicular along the distribution of the spinal tracts which are compressed (and typically described as a tight or cold sensation).

Spinal pain is non-mechanical in nature, which means it is present when the patient is not moving. The characteristic spinal pain due to metastatic disease is dull. It increases with time, requiring increasing dosage and potency of analgesics. It is exacerbated at night when the patient is supine. Activities producing a Valsalva maneuver will also often increase the pain (2,3,5,6,9,10,11,12,14).

The pathogenesis of pain can be attributed to bony destruction with periosteal distention, instability, pathologic fracture, or compression of spinal cord or root. Pain conducting fibers are located in the anterior and posterior spinal ligaments, the fibrous capsule surrounding the intervertebral disc and the dura. Stretching or compression will excite these nerve fibers. Direct compression of the cord causes little pain, but direct compression of the nerve roots may cause severe radicular pain (12,13).

At the time of diagnosis, 76% of patients complain of weakness and 86% exhibit muscle weakness on clinical examination. Sensory disturbances such as numbness or paresthesias are noted by 51% of patients, but sensory deficits were found in 65% of patients on examination. Bowel and bladder dysfunction did not occur as a presenting complaint in several major series. However, 57% of patients had urinary retention. Fifteen percent of patients did not present until

paraplegic in spite of prior spinal or radicular pain (3,12,14).

Several syndromes are related to spinal metastases including:

1. **Horner's Syndrome** - Characterized by miosis, pseudoptosis, apparent enophthalmos, and dryness of the skin over the face. This occurs due to involvement of the paraspinal sympathetic chain.
2. **Pancoast's Syndrome** - Characterized by motor weakness and pain in the distribution of the C-8 and T-1 nerve roots, as well as Horner's Syndrome, which results from involvement of the inferior cord of the brachial plexus due to tumor mass of the superior pulmonary sulcus.
3. **Pain in the thoracic region** - Mimics anginal pain and radiates anteriorly unilaterally or bilaterally.
4. **Pain of the lumbar spine** - Resembles an acute abdominal pain and radiates into the anterior abdominal wall.
5. **Herpes zoster** - Several authors have reported that the eruption of zoster will presage an episode of spinal cord compression at the same level. Other authors consider that the virus in the dorsal root ganglion is activated by tumor invasion.
6. **Brown-Sequard Syndrome** - Characterized by ipsilateral weakness, position loss, contralateral pain and temperature impairment.

Signs

Signs of cord compression are generally symmetric, while those of radicular compression are generally asymmetric. Compression of the cord produces a myelopathy with weakness and spasticity below the level of the lesion, sensory loss, and often bowel and bladder dysfunction. Early signs of anterior compression may manifest as motor weakness, impairment of pain sensation (spinothalamic tract and anterior lateral cord), but intact touch and position sense (posterior columns).

In the thoracic spine, the level of sensory loss is the only way to localize the level of involvement. The cord level is generally one to two levels below the vertebrae involved (since cord levels are higher) (4,5,12).

In situations of chronic compression, spasticity, hyper-reflexia and extensor plantar response are found, whereas in acute compression, all reflexes below the level of the lesion are usually absent due to spinal shock. The loss of abdominal reflexes, which come from T8 to T12, are useful for localization. Saddle anesthesia, loss of bowel and bladder control and plantar extensor reflex should alert one to compression of the cauda equina or conus medullaris (4,12).

Prognosis

Important determinants of functional prognosis in patients with spinal metastasis are:

1. Pretreatment neurologic status;
2. Tumor biology, i.e. the natural history of the systemic malignancy;
3. Location of the tumor in the spinal canal; and
4. The kind of therapy employed (3,5,6,7).

There is a strong correlation between the pretreatment motor status and the functional outcome since 60%-70% of the patients who could walk at the time of diagnosis will retain the ability to walk after treatment (6). This is in contrast to those who were paraparetic, of whom only 35% retained the ability to walk after treatment, and the fact that 28% of these patients become paraplegic in less than 24 hours.

The percent of patients who are paraplegic and regain the ability to walk varies from 0% to 25%, depending on the series. Gilbert reports a 5% recovery, White reports a 10% recovery, and Livingston and Perrin report the highest rate of recovery at 25%. But, the success rate in these studies depended upon the definition of "plegia." In some series, this meant loss of all cord function, while in others it included some preservation of neurologic function. Of the patients with some neurologic function, 20% - 25% regain ambulatory status as opposed to none of the patients without neurologic function pretreatment (1,3,6,15).

The rate of onset and duration of symptoms is also of value for prediction. A rapid onset of symptoms holds a poorer prognosis than one of slow progression. Once paraplegia has appeared, the duration of paralysis also has prognostic significance. Twenty percent of patients who are paretic greater than 24 hours regain ambulation, whereas 0% who are paraplegic for greater than 24 hours regain the ability to ambulate. In addition, patients who have lost bowel and bladder function have a poorer prognosis than those with function intact.

The biological activity of the tumor is another important determinant in the neurological outcome. Tumors with a favorable prognosis are myeloma, lymphoma, Ewing sarcoma, neuroblastoma and carcinoma of the breast. Bronchogenic carcinomas generally do poorly. The prognosis of many tumors is also related to their radiosensitivity (3,6).

The segment of the spinal cord at which the epidural mass is located has been related to functional outcome. This is due to the variable density of radicular arteries and, therefore, collateral circulation. The collateral supply is poorest in the upper three cervical segments, at T-4, and at L-1. Interference with blood flow at these levels due to compression is more likely to result in ischemic necrosis. Tumors which are located posteriorly have a better functional prognosis than those which are located anteriorly.

Pathophysiology

The epidural space is defined by the periosteum of the vertebral canal, ligamentum flavum and the dura of the spinal cord. It is a true space with no lymphatic channels or lymph nodes that is filled with loose areolar tissue, arteries, veins, and connective tissue. The high incidence of vertebral body metastasis is thought to be due to the valveless epidural venous plexus of Batson, which also drains the vertebral bodies, allowing bidirectional flow and direct communication with the thoracic and pelvic venous systems (2).

Epidural tumors cause obstruction of the epidural venous plexus (8) and the resultant back pressure enhances the production of vasogenic edema. This edema involves the white matter and ultimately spreads to the grey matter in the later stages of compression. The blood flow to the spinal cord is diminished due to this stasis (2).

In addition, the neural tissue is also deformed by the epidural mass. The ability of the spinal cord to adjust to these forces is determined by the rate of compression and the level of the spinal cord at which the compression is located. This is related to the density of radicular arteries and, therefore, collateral circulation which varies at different levels of the spinal

cord (2,8).

As previously mentioned, collateral supply is poorest in the upper three cervical segments, at T-4, and at L-1. Decompensation from compression and accompanying decreased blood flow may occur in hours or days from the time the signs of compression have become manifest. This ischemic insult can cause irreversible loss of function if the compression is not alleviated rapidly.

In an experimental study, it was shown that edema is associated with PGE-2 production. Dexamethasone fails to decrease PGE-2, whereas methylprednisolone and indomethacin do decrease production. It is not clear if the decrease in edema correlates with delay in the onset of paraplegia. Dexamethasone and indomethacin correct the specific gravity abnormalities after 30 hours of treatment, and both delay the onset of paraplegia, whereas methylprednisolone does neither. The clinical efficacy of pharmacologic agents seems to relate to spinal cord specific gravity and not to edema (6).

Laboratory tests

A complete blood count should be done on all patients. Anemia can be seen due to blood loss from gastrointestinal cancers or from decreased production due to renal cell carcinoma. Leukopenia, anemia, and thrombocytopenia indicate the possibility of bone marrow involvement (10,12).

The prothrombin time (PT) should be checked. Prolongation suggests liver involvement with tumor, and until corrected would increase the risk of surgery (12).

An electrolyte panel will indicate volume status, renal failure, and acid base status. An elevated calcium suggests widespread bony metastasis. Total protein and globulin indicate a patient's nutritional state and, if the globulin fraction is elevated, multiple myeloma should be suspected and protein electrophoresis and Bence Jones proteins ordered. Uric acid will be elevated in those patients with hematologic malignancies. Liver enzymes (gamma glutamyltransferase, aspartate aminotransferase, alanine aminotransferase, alkaline phosphatase) should be checked to look for liver metastasis (12).

Serum tumor markers are useful in the evaluation and in the follow-up of malignancy. Prostate cancer is associated with a rise of the serum acid phosphatase or prostatic specific antigen. Carcinoembryonic antigen (CEA) is typically elevated with cancer of the colon, but it may also be elevated with other solid tumors. Beta human chorionic gonadotropin or alpha fetoprotein may be found in testicular or ovarian carcinomas. Serum catecholamines, vanillymandelic acid or homovanillic acid, may be elevated in patients with neuroblastoma or pheochromocytoma (12).

CSF should be obtained at myelography and be sent particularly for protein and millipore filter. Protein is elevated in patients with epidural spinal cord compression. CSF for millipore filter is used for the evaluation of leptomeningeal carcinomatosis, although the initial cytology is positive in only 60% of patients with leptomeningeal disease (12).

Diagnostic imaging

Plain X-ray films should be obtained if metastatic spine disease is suspected since abnormalities will show up in 60% of these cases on this medium. Physicians must remember that vertebra must undergo about 50% decalcification in order for lesions to be visualized by plain X-rays, and early lesions may not be seen. Complete evaluation of the spinal axis should be performed since in approximately 17% of the cases, multiple metastases are found. Radiographic signs of tumor include destruction of the pedicles, partial or complete collapse of a vertebra, osteoblastic infiltration of vertebra, or paraspinous soft tissue mass (2,5,7,8,12).

Bone scans are useful in the detection of metastases in the axial and appendicular skeleton. Bone scans are positive in 36% of patients in which plain films were negative. Plain radiographs may lag three months to 18 months behind bone scans in the detection of a tumor. Bone scans have the disadvantage of lacking the specificity of plain radiographs, CT and MRI. In addition, trauma, infection, and degenerative disorders will cause false positives, and multiple myeloma and thyroid carcinoma consistently fail to be detected by bone scans (2,5,12).

The most commonly used radiologic study to demonstrate spinal cord and root compression has been myelography followed by CT. Myelography will demonstrate the level, the extent of the mass, and if it is intradural or extradural. CT exam of the areas of block or compression are essential to delineate in greater detail the extent and location of the vertebral involvement and the position of the mass in relation to the spinal cord.

In evaluating metastatic spine disease by myelography, it is essential to visualize the upper limit of the block. A second puncture at the C-1 C-2 interspace may be necessary if dye does not flow from below. Another technique to visualize the rostral extent of the block is to perform a delayed CT scan approximately one hour after the initial CT. Neurologic status may deteriorate after myelogram due to downward herniation of the cord because of reduction of CSF pressure below the lesion. Therefore, consultation with a neurosurgeon prior to myelography is prudent (2,5,10,12,16).

If the myelogram is negative in a cancer patient with neurological symptoms, meningeal carcinomatosis, carcinomatous myelopathy and carcinomatous neuropathy must be considered. If the patient has received radiation therapy, then radiation myelopathy must be considered. This can occur as early as several weeks after therapy, but usually it is seen nine months to 24 months after completion of treatment. Other possible causes of cord syndromes that should be considered include multiple sclerosis, amyotrophic lateral sclerosis, or transverse myelitis of unknown etiology (2,4,12).

MRI is becoming the current study of choice for spinal cord compression in some centers because it is non-invasive and does not expose the patient to ionizing radiation. T-1 weighted images demonstrate excellent anatomic detail of the spinal cord and bone marrow of the vertebral body. The disadvantages of MRI include accessibility and the length of scan time the patient must remain motionless. T-2 weighted images demonstrate disc space and subarachnoid space. Tumors show decreased signal intensity on T-1 and increased intensity on T-2 weighted images. MRI also allows the cephalad and caudad extent of the tumor to be visualized (2,16).

There have been comparisons between MRI and myelography. Smoker and colleagues reported a series of 22 patients in which myelography, CT-myelography, and MRI were compared in the diagnosis of epidural metastasis. Myelography was diagnostic in 16 of the 22 cases, and MRI was diagnostic in 19 of the 22 cases. In a study of 19 patients

with systemic cancer who were being evaluated for back pain or myelopathy, Hagenau and co-workers demonstrated small clinically significant epidural lesions in nine of the 19 patients which were not demonstrated by MRI.

In spite of the fact that lumbar puncture is still needed for CSF examination for diagnosis of leptomeningeal carcinomatosis, MRI will likely continue to increase in its role for the evaluation of metastatic spinal disease (2,7,12).

Non-operative care

Management of epidural spinal tumors must be based on the individual patient and the factors that must be considered include:

1. The patient's neurologic condition;
2. Tumor biology;
3. The site of involvement of the tumor;
4. The rate of progression of symptoms;
5. The general medical condition of the patient; and
6. The age of the patient (6,17).

Corticosteroids are efficacious in the management of epidural tumors with cord compression and they act by relief of vasogenic edema. In certain tumors of the round cell variety (lymphoma and neuroblastoma), evidence exists that steroids have an oncolytic effect. However, there are potential side effects of steroids including gastrointestinal bleeding, steroid myopathy, hyperglycemia (especially in known diabetics), interference with anticonvulsants, poor wound healing, infection and pseudorheumatism from too rapid of a taper. The majority of these side affects occur after the patient has been on steroid therapy for periods of greater than one month (10).

Once the diagnosis of epidural tumor has been made, most physicians agree that radiation therapy is the first choice of treatment. As a general rule, one-third to one-half of the patients treated with radiation therapy will improve and remain neurologically stable at the end of one year, 60% will obtain pain control, and 30% will be able to discontinue narcotics. Patients with breast, prostate, and hematogenous tumors are most likely to respond favorably to radiation therapy alone.

A major complication of radiation therapy is radiation myelopathy. This is not a problem with the patient who has a limited life expectancy, but it is a concern for the patient with a favorable prognosis. Radiation myelopathy is not related to the total dose, but rather to the treatment time and the total number of fractions used.

Deterioration while undergoing radiation therapy may reflect radioresistance or compression as a result of vertebral collapse. Experimental studies do not support the concept of edema induced from radiation as a cause for neurologic deterioration. When used after surgery, the major problems include poor fusion when bone graft has been used, poor wound healing, and sepsis, especially when the patient is also taking steroids (3,5,6,10,13).

The use of specific chemotherapy is best determined by the oncologist. The advantages of chemotherapy prior to surgery are the reduction of the tumor mass, as well as the early treatment of micrometastasis.

Surgery

Indications for surgical intervention for epidural metastasis include the need to make histologic diagnosis, spinal instability, compression by bone in the spinal canal, recurrent tumor when no additional radiation therapy can be given, radioresistant tumor, and neurologic deterioration while undergoing radiation therapy (13,14,17). The traditional approach was laminectomy followed by radiation therapy, but the outcomes of this approach were not superior to radiation therapy alone. As a result, there are still many physicians who favor steroids and radiation therapy as the initial treatment of choice.

Reasons for past surgical failures in the treatment of epidural metastasis include non-selective use of a single surgical approach, insufficient surgical resection of tumor and bone, failure to stabilize, and intradural extension of the tumor. In view of the recent articles about the variety of approaches which can be used to tailor the surgery to the location of the tumor, the role of surgery as a procedure of diagnosis or salvage must be re-evaluated (2,3,6,13,14,17,18).

The patient's preoperative neurologic condition is the most important pretreatment variable in relation to his/her surgical outcome. Surgery should be reserved for those patients who still retain some degree of motor function. It is not considered beneficial for patients who are paraplegic or near paraplegic after aggressive decompression and instrumentation, or who have a rapidly evolving deficit over the prior 24 hours in the face of steroids. However, patients who develop paresis or plegia slowly may benefit from anterior decompression (6,13).

Patients with cord compression from bone (after collapse or deformity), spinal instability due to tumor erosion, and those who deteriorate while undergoing radiation therapy are surgical candidates if their life expectancy is greater than six weeks (13). Laminectomy is still the procedure of choice if the tumor is located posterior or posterolateral (situated between the cord and the ligamentum flavum) (10).

Eighty-five percent of epidural tumors arise in the vertebral body and invade anteriorly and remain anterior. The anterior approach has become the gold standard for such tumors because it permits adequate exposure and visualization of the extent of the tumor, allowing for aggressive and extensive decompression. The anterior approach also allows for anterior stabilization and does not disrupt the posterior column, which is still intact in the majority of instances.

In the thoracic spine, direct anterior resection of the tumor with stabilization can achieve the goals of decompression and stabilization. This approach is also useful in that it allows better exposure for resection of paravertebral soft tissue masses (3,6,8,9,14,15,17,19). An anterolateral approach with vertebral body resection can also be used when the involvement is predominately anterior.

There are the following circumstances in which it is advantageous to utilize the posterolateral approach:

1. It is better tolerated by patients whose medical condition would prohibit the use of an anterior approach;
2. It allows access to the spine when all three columns are involved;
3. Posterior instrumentation can be incorporated with relative ease;
4. It allows better access if the major portion of the tumor is posterior and lateral; and
5. It allows access if there is multilevel involvement which is discontinuous. This approach is not suitable for the cervicothoracic and the lumbosacral junction; and it is not recommended when an

anterior approach can be performed since the posterolateral approach does not allow the exposure for resection. Following treatment by this method, the ambulatory rate is 65% with a gain of ambulation of 28% (20).

Of the patients with ventral tumor, 9% to 16% of them remained ambulatory if decompressed posteriorly. In addition, 30% to 50% of the patients with posterolateral tumors remained ambulatory if decompressed posteriorly, whereas 70%-80% of the patients with anterior compression remained ambulatory if decompressed anteriorly (3,6).

Posterior stabilization may be required in conjunction with surgical decompression if there is instability. Instability is defined in cancer as a translational deformity, three column involvement of the spine, loss of vertebral height of greater than 50%, or pain which is exacerbated by movement. At times, stabilization alone may be performed in patients who develop instability and pain after undergoing successful treatment of tumor by radiation or chemotherapy.

Posterior stabilization can be performed with plates, screws, rods, steel rectangles, and wires. The choice of the exact type of posterior stabilization depends on the region of spine involved, the number of levels involved, the number of columns involved, and the surgeon's preference (1,6,10,13,21,22,23).

After spinal surgery, patients should be monitored carefully due to the risk of neurological deterioration, cardiopulmonary complications, sepsis, deep vein thrombosis and subsequent pulmonary emboli, and the fact that they are often immunosuppressed and in poor medical condition.

Conclusion

Epidural spinal cord compression from metastatic disease is a problem which will face physicians in all types of practices with increasing frequency. Thus, it is important for the physician to be aware of the history and physical findings seen in this disease entity.

Once the physician suspects metastatic disease to the spinal column with or without spinal cord compression, it is imperative that he/she be sensitized to the risk of rapid progression and the need for immediate diagnosis and treatment. The neurosurgeon should be involved early and to help plan diagnostic studies and treatment.

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Geophagia in a chronic hemodialysis patient

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Abstract

Geophagia, the deliberate ingestion of earth, is a serious clinical problem, particularly for dialysis patients. This article presents a geophagic patient with end stage renal disease and reviews the etiology, consequences and treatment of this disorder.

Introduction

The practice of geophagia by dialysis patients may lead to significant morbidity and mortality. Life-threatening hyperkalemia has been previously described as a consequence of geophagia in patients with chronic renal failure (1).

In this article, we describe a patient with chronic renal failure on hemodialysis who was unique in that she ingested common sedimentary sandstone -- not clay, dirt or pebbles as reported in other cases of geophagia (2-5). This patient is a West Virginia native, who is the first reported case from the Charleston area. Her craving for the stone was related to both nutritional and psychological variables, and this article discusses the etiology, consequences, and possible therapeutic interventions for geophagic patients.

Case report

A 29-year-old black female with end stage renal disease revealed her habit of geophagia to her physicians during her most recent hospitalization at the Charleston Area Medical Center. She had begun eating foreign materials soon after hemodialysis was instituted, first trying green apples and clay before settling on sandstone. No other family members or acquaintances practiced geophagia.

Almost every day, this patient had been eating 100 grams to 300 grams of sandstone, which she described as pleasurable because of both its taste and "crunchy" texture. She said she occasionally baked the sandstone in the oven and her craving for it was strongest when she felt frustrated, stressed at home, or sexually aroused. The craving diminished after blood transfusions and was unrelated to dialysis treatments.

Her psychiatric history included intermittent depressive episodes, neuropsychiatric manifestations of her systemic lupus erythematosis (inappropriate affect, visual and tactile hallucinations), and occasional euphoria secondary to steroid therapy. During this admission, she remained somewhat depressed regarding her poor health. She also admitted embarrassment, shame, and sadness regarding her geophagia, which she did not understand and could not control.

Pertinent history included a microcytic, hypochromic anemia which developed in 1982, antedating the onset of complete renal failure and geophagia by approximately one year. She had remained chronically anemic with normal RBC indices and was maintained on ferrous sulfate (650 mg./day), receiving many intermittent transfusions. At the time of this admission, her laboratory data included Hb.=5.8 gm./dl., Hct.=17, Na=136, K=8.1, Cl=100, CO_2=21, BUN=108, Cr=18.2, and Glu=94.

Further workup for geophagia included a normal serum iron (128 mcg./dl.), TIBC (330 mcg./dl.), serum zinc (75 mcg./dl.) and serum copper (107 mcg./dl.). Her stool was heme negative and an abdominal X-ray showed abundant fecal material in the colon and a small calcified phlebolith. She was started on psychotherapy with positive reinforcement and was also encouraged to construct barriers to decrease availability of the sandstone, and her iron therapy was to be continued.

Discussion

Although cultural influences are clearly responsible for the practice of geophagia in many instances (2,6-8), our patient reported no previous exposure to the habit of geophagia or pica through friends or relatives. Her geophagia could, therefore, not be traced to any factors related to her environment from birth to the present.

There are also nutritional theories concerning the etiology of geophagia which center around deficiencies of iron (9-11) and zinc (12,13) as a cause of pica in children, although the relationship of zinc deficiency to geophagia is unclear (14). Our patient was clearly anemic prior to the onset of her geophagia, however, her habit of geophagia did not develop until one year later. She remained geophagic and anemic despite iron therapy and normal serum iron and TIBC. This fact, as well as the subjective decrease in the craving following transfusions, may support a etiologic relationship between the anemia (rather than an iron deficiency) and geophagia. This is contrary to previous reports which conclude that geophagia is related to iron deficiency as demonstrated by decreased geophagia with iron therapy prior to correction of the anemia (10,11). In addition, our patient demonstrated normal serum zinc, so this factor did not seem related to her geophagia.

Psychological factors have been implicated as potential causes of pica in general, of which geophagia is a subset. Studies of pica in children suggest numerous theories including oral fixation, desire to chew solids (15), as well as craving the taste, color, or texture of the substance eaten (6). In one study, maternal deprivation, parental neglect, and poor parent-child relations were among the factors found to be more prevalent among children with pica (16).

Our patient reported a strong craving for the taste and texture of the substance, which was stronger at times of stress (she is unemployed living on a fixed income, undergoing hemodialysis, divorced, supporting one child, and living in public housing.) Depression about her chronic illness and feelings of inadequacy regarding her parental abilities and financial resources contributed to her geophagic craving. She also reported that sexual arousal heightened her craving and increased her geophagia.

Metabolic consequences of geophagia include hypokalemia (17) and hyperkalemia (1), and decreased serum levels of minerals such as iron and zinc (18). Other complications have included rectal bleeding (5), colonic obstruction and perforation (2), parasitic infestation, constipation (6),

allergic reaction (19), increased incidence of toxemia in pregnancy (20), and maternal death (21). Also syndromes of hypogonadism, hepatosplenomegaly, and iron deficient anemia (22), as well as cachexia africanus (23) have been reported.

Our patient's anemia was attributed to chronic renal failure and systemic lupus erythematosis. She had no complaints of constipation or abdominal pain and no dental injuries from eating the sandstone. She had experienced only one recent episode of hyperkalemia and this condition did not seem to be a recurrent problem. The psychological effects reported by this patient included severe embarrassment, shame, anxiety and reclusiveness in an attempt to conceal her behavior. Her relationships with family and friends had deteriorated because they regarded her geophagic behavior as quite bizarre.

Therapy for geophagia can be divided into two categories: nutritional and psychiatric. Nutritional therapy centers around supplementation of minerals -- primarily iron and zinc. Therapy with iron in patients who are iron deficient has successfully terminated the behavior (10,24). Zinc therapy of pica in children has been successful in patients found to be zinc deficient (12,13). Our experience with this case suggests correction of any anemia as a useful modality for lessening geophagia.

Behavioral techniques in the past have been based upon actual physical restraint, though this was frequently unsuccessful (6). Techniques of negative reinforcement for practicing geophagia and positive reinforcement for refraining from geophagia are current techniques being employed (6). The necessity to eliminate "psychological stress" has been pointed out by previous authors as an important aspect of complete management of children with pica (16).

Conclusion

When called to evaluate dialysis patients with periodic hyperkalemia or acute neuropsychiatric changes, the psychiatric consultant should inquire about geophagia. To help establish the etiology of geophagia, a thorough history should be taken, clinical presentations must be reviewed, and an appropriate laboratory workup be conducted. An understanding of the interplay between psychological and physiological factors is helpful in managing geophagic patients and may reduce their morbidity and mortality.

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Cancer crosses all cultures and all nationalities without exception. So it stands to reason that the treatment and eventual cure of a condition experienced worldwide would require talent and intellect from around the globe.

That's why the planners of The Arthur G. James Cancer Hospital and Research Institute, a National Cancer Institute designated Comprehensive Cancer Center, set out to staff this promising medical center with the top researchers in their field, wherever they might be found. Their search resulted in a respected team of renowned specialists from all around the world.

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sciences, pharmacy and veterinary medicine, has enabled research efforts to advance efficiently while benefiting from the resources of one of the nation's leading University medical programs.

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pproach to research is so integrated, the lag time between laboratory breakthroughs and practical application is dramatically decreased. Collaboration between research teams and clinical specialists of the Comprehensive Cancer Center, which are composed of University graduate programs in chemistry, biological

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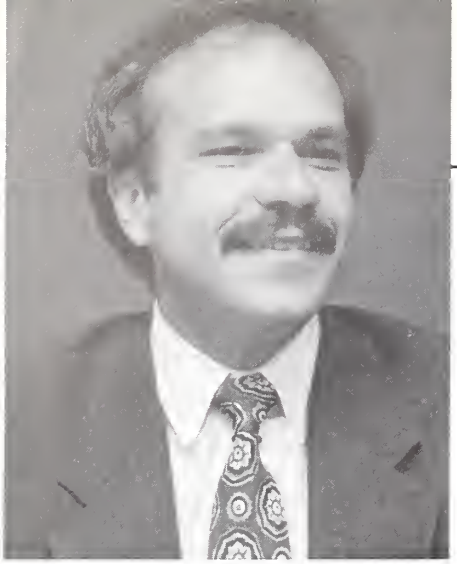

President's Page

James L Comerci M.D.

To legislate or not to legislate?

Too often government leaders act as if change will not occur unless they intervene with new laws and regulations. The health care delivery system in West Virginia is a perfect example of how changes can occur without legislation.

What am I talking about? The rate of rise in medical expenditures in the state has slowed to 6%-8% as compared to 14% a year ago. In some areas of West Virginia, over 80% of the individuals with medical insurance are covered by a plan that sets reimbursement rates and limits out-of-pocket expenses. In almost every part of the state, established health care delivery networks are expanding and new networks are being explored or developed. In addition, a rural health initiative is exposing young physicians, pharmacists, nurses, and other health care professionals to patient care in rural areas.

How can all of these positive actions have taken place without legislation? One reason is that physicians and patients have been working together in several areas of the state to improve their health care delivery systems. A second important factor is that hospitals and physicians have been interacting to create networks with businesses and consumers. Another critical reason is that doctors, nurses, hospital employees, secretaries, bankers, accountants and people in all segments of society are working to staff free clinics for the indigent. The bottom line is that throughout West Virginia, medical and non-medical groups are talking and taking actions to improve the way we deliver health care in the state.

So, the question remains -- Do we need to legislate major changes in health care or not? In West Virginia, we now have spent more than two sessions of the Legislature debating this subject. Time which could have been devoted to really solving problems in health care. There has been no real combined effort by state government to involve consumers and health care providers in legislation that is drafted. Yes, consumers and health care providers have been able to voice their opinions to some extent on issues, but they have not been specifically asked to help develop health care legislation.

Where do we go from here? First, we must answer questions that **can** be answered.

Do we need to spend our health care dollars more efficiently and make the system more cost effective? **YES.**

Do we need to find ways to provide coverage to those who may be able to afford it if the costs were lower? **YES.**

Do we need to find ways to provide care to those who cannot possibly afford it? **YES.**

Do we need to find ways to make people more responsible for preventing illness? **YES.**

Do we need legislation to accomplish this? **MAYBE NOT.**

Do we need a major overhaul of the state's entire health care system? **NO.**

It's time that consumers, health care providers and government leaders leave their baggage at the door and come together to develop some real solutions. Can we put together a group that would be able to achieve this goal without legislation? I think this will be the answer. As physicians, we must be willing to be a part of the solution.

James L. Comerci, M.D.

Saving big dollars

Well, all right then, let's talk about dollars. Everyone, including doctors, is agreed that medical care costs too much.

The problem is really not access. There are no pandemics, no bodies lying about in the streets. There is no one who will challenge the fact that the quality and technological sophistication of health care in this country are unmatched anywhere on this planet.

Medical care just costs too much -- so much that other things in the household budget like vacations, dining out, entertainment of various sorts, stylish clothing and new cars are being squeezed out. This list could be extended in any number of specific and non-specific directions, none of them inherently bad.

Since the problem is indeed scarce dollars rather than limited access, discriminatory insurance or a dysfunctional organizational setup, let's look at how we might conserve dollars without damaging quality. Hillary attempts saving money via a very poorly disguised system of rationing. She and her health care guru, Magaziner, lop off a hundred million here and a few billion there. They fancifully project systemic and attitudinal conversions among the 80% or more of the consumers presently satisfied with their care, and with straight faces proclaim that all the figures balance out and everyone will now be able to snuggle down, happy in their new found security.

A recent piece in the *New York Times* suggests that administrative costs presently account for more than 40% of total medical care costs. This is a startling figure, but when one considers the number of employees found in administrative offices of any hospital; the non-medical workers filling out insurance forms and other required records in the ordinary doctor's office; insurance company employees examining materials generated at doctors' offices and hospitals and then filling out more forms and papers; the battalions of health care managers busily churning out forms and phone calls; the controllers, regulators and rule makers sitting in their government offices doing whatever they do to fill their day; it begins to seem possible that at least 40% of medical care costs can be attributed to other than doctors and nurses who, at the very least, are terribly outnumbered by these others.

Of course, Hillary promises to do away with a lot of the paperwork we refer to. She proposes to do this by creating a bureaucracy on a scale previously unheard of and perhaps even undreamed of for our or any other government, including that of the Soviet Union which attempted to manage and control just about everything. Her plan will certainly eliminate much of present day medical paperwork, but what she does not mention is that her plan will simply replace that with an even greater burden of new and different paperwork.

With total costs for medical care in the United States approaching $1 trillion yearly, 40% amounts to roughly $400 billion, which presents a rather fat target for anyone honestly interested in saving dollars. At any rate, that route seems a far more humane approach to economy than denying bypass surgery to those beyond 70 years old, dialysis to those over 55, joint replacements to those over 75, or any number of other similarly excellent cost savers.

As fine a target for cost cutting as administrative costs appear to be, there are realistically certain limits that can be expected in the pursuit of economy in that direction. Economies available in administrative costs pale, however, in comparison to those available via tort reform and the subsequent effect of that reform on defensive medicine.

In overall medical care costs, professional liability premiums paid by doctors seem perhaps insignificant -- probably $6 billion to $7 billion out of nearly a $1 trillion medical care figure. To keep themselves out of the hands of rapacious and predatory plaintiff lawyers, however, most doctors, probably all doctors, are willing to go the extra mile in being careful. They want to be sure. Doctors know this costs a lot of money but they like to sleep at night. Then too, they have a high regard for their reputations.

They dislike spending hours, days, even weeks giving depositions or court testimony. It makes doctors nervous to be harassed by the likes of lawyers. It makes doctors angry to endure the insults of, or even the presence of lawyers.

To the extent doctors can be reassured, sleep at night and feel relatively protected from the circling pack of slavering legal wolves, it costs patients and their insurers a substantial amount of money. The least amount of money attributed to defensive medicine costs is $30 billion. The high estimate is 10 times that, about one third of total medical care costs, a figure in the neighborhood of $300 billion.

If we were to take the advice of one Shakespearean character -- "First, kill all the lawyers" -- we might be able to save 100% of that amount. Short of that drastic but in some ways attractive step, we can save some very significant part of the defensive medicine cost figure.

Now, we are talking about some real money and we haven't yet mentioned product liability suits by the same legal parasites and the effect of these on the cost of drugs.

Yes, medical care costs can be brought down dramatically, and we can accomplish this without rationing and without affecting the quality of medical care. If it is done right, the only unhappy group remaining will be plaintiff attorneys. That seems like an acceptable price to pay. Nobody likes them anyhow.

– Stephen D. Ward, M.D.
Editor

In My Opinion

The new physicians -- kill or cure?

The activities of Dr. Jack Kevorkian and recent referendums proposing euthanasia in the states of Washington and California that were only narrowly defeated, suggest that the role of physicians in the United States may be changing from merely treating diseases to a more active one.

Since pre-Christian times, the Hippocratic Oath has made a sharp distinction between the physician as a healer and as a killer. A 1988 article in *JAMA* powerfully stated that a physician cannot be both (1). At times, physicians have played a dual role -- most notoriously in Hitler's Germany.

In spite of the very low, and perhaps vanishingly rare incidence of truly intractable pain (2), physicians are becoming more involved in suicide and euthanasia, as well as in such activities as the legal executions of criminals (3). In an alleged era of limited resources, society may indeed need to examine the cost of preserving life. It likewise needs to examine the cost of failing to preserve life.

Oregon has recently proposed to limit the care available to certain categories of patients, acknowledging the fact that, as a direct result, some patients will die. Limits can now be placed on the actual length of a person's life to prevent "needless" expenses during the process of dying.

Society might even come to recognize that transplantation medicine would greatly benefit from a reliably available supply of organs from elderly patients or executed criminals. Society would then have a great need for doctors willing to expedite killings or executions. In the future, society might further demonstrate its need for such doctors by mandating limits on the number or types of children allowed to live, easily extending this to infanticide like China's brutal population control program (4).

In anticipation of these or similar happenstances, I propose the creation of the position of Doctor of Necrotology or N.D. The N.D. would be by statute our society's only legal killer of innocent human life. The sole mandatory requirement for the position of N.D., other than sufficient intelligence to utilize the "tools of the trade," would be compassion -- either for suffering patients or for the members of society as a whole.

Indeed, possession of the virtue of compassion to the greatest possible degree will be absolutely essential for the successful performance of the N.D.'s duties. In no other way could we successfully overcome strongly built-in Western cultural and ethical aversions to the killing of an innocent person. It is obvious that careful legal limits would have to be established for doctors in this specialty. The historical record shows how easily the role of licensed killer can be corrupted or perverted.

Physicians currently assisting in the judicial execution of prisoners or performing elective abortions, of course, would be grandfathered the N.D. degree. With the passage of appropriate laws, the roles and numbers of these specialists would grow. N.D.s would perhaps find it difficult to fit comfortably into conventional medical societies. However, because of their dual medico-legal sanction, they would easily find compatible brotherhood as a component society of the American Bar Association.

The final result is that the clear dichotomy between Doctors of Healing and Doctors of Death would be re-established, and medicine could regain its soul.

Robert C. Belding, M.D.
Beckley

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Special Correspondence

Dear Dr. Ward:

Greetings from Scottsdale. I wrote the following satire today and thought you might want to publish it in the *West Virginia Medical Journal.*

Two months ago I paid for my last haircut at Tony's. It cost $8 plus a $2 tip. Now, I have an insurance policy with a preferred barber organization (PBO). For $100 a year I can have all the haircuts I need, but of course, I must go to a participating barber shop.

Yesterday, I selected Sam at Preferred Barbers of America (PBA). They are a participating provider. Sam had a few suggestions. He said I'd look a lot better if I had my hair cut once a month (instead of every other month) and it would be covered by my policy providing I had a second opinion form completed. This form could be provided by any participating barber shop other than PBA. Sam suggested Family Barbers of America (FBA) since they often provide second opinion forms for each others customers.

Sam also said that I would look spiffier if I got a style cut. He explained that even though a style cut would cost $5 more than the standard $10 haircut, I would only be responsible for half ($2.50) and they would be glad to bill me for it. In addition, he said after I had met $20 of co-pays per year, there would be no more charges to me.

Well, I wasn't thrilled with Sam's haircut.

Why, I asked, didn't he shave around the ears and trim my nose and eyebrows like Tony always did. Sam explained that those were not covered benefits under the basic plan. The premium for the deluxe haircut plan was $150 per year.

At my insistance, Sam had his secretary show me the bill that his billing clerk would be submitting for my haircut.

Basic haircut	$10.00	
Style	2.50	($5.00 x 50%)
Wash	1.00	
Drape	1.00	
Gratuity (15%)	2.18	
Billing fee	2.00	
Total	$18.68	

I asked Sam how my PBO could afford to provide these services for $100 per year. Sam explained that they really cannot, but they were losing money in an attempt to capture the market share and that the premiums would be going up 30% next year.

I went back to Tony and asked why he did not participate as a provider for my PBO. Tony explained that he would have to invest $30,000 in a computer for billing the PBO electronically and he'd have to hire another employee to do the billing. He decided instead to stick it out for one more year and retire early.

Harold L. Saferstein, M.D.

Editor's Note: *Dr. Saferstein retired from his dermatology practice in Wheeling, W.Va. at age 59 and now lives in Scottsdale, Ariz.*

AMA president to deliver address at Annual Meeting

Robert E. McAfee, M.D., who will become president of the AMA in June, will discuss political issues affecting the practice of medicine when he speaks at 9 a.m. on August 20 during the Second Session of the WVSMA's 127th Annual Meeting at The Greenbrier in White Sulphur Springs.

A surgeon practicing in South Portland, Maine, Dr. McAfee has been serving as president-elect of the AMA since June 1993. Prior to this, Dr. McAfee served as vice chair of the AMA Board of Trustees from 1990-92; as a member of the Executive Committee of the board from 1988-92; and as an AMA commissioner to the Joint Commission on Accreditation of Healthcare Organizations from 1986-93. In addition, he also served as president of the AMA Education and Research Foundation from 1986-88, and as its secretary-treasurer from 1985-86.

Before his election to the AMA Board of Trustees in June 1984, Dr. McAfee was a delegate to the AMA House of Delegates from 1974-84, and chair of the New England Delegation from 1976-84. A past president of both the Cumberland County Medical Society and the Maine Medical Association, Dr. McAfee is also a past member of the Board of Directors of the Maine Health Systems Agency, the Project Review Committee (Certificate of Need) and the Board of Directors of Maine Blue Cross and Blue Shield.

McAfee

A native of Portland, Dr. McAfee received his M.D. degree from Tufts University School of Medicine in 1960. He completed his residency in general surgery at Maine Medical Center in 1965, where he served his internship. An attending surgeon at Maine Medical Center and chief of vascular surgery at Mercy Hospital in Portland, Dr. McAfee is also currently an associate professor of surgery at the University of Vermont.

Dr. McAfee is on the Executive Committee and is a past president of the American Cancer Society, Maine Division, and also serves on the American Cancer Society's National Board of Directors. In 1981, he received the American Cancer Society's Frederick G. Payne Memorial Award, and in 1986 was presented with the National Bronze Award, the highest award given to a volunteer of the American Cancer Society.

A member of the Medical Advisory Board for Community Health Services in Portland, Dr. McAfee is the first recipient of the O'Wril Award for Community Service in Communication from the Gannett Broadcasting Company in Portland. He is also the 1985 recipient of the Huddilston Medal of the Maine Lung Association and the 1989 Governor's Medal from the Emergency Medical Services Board for his contributions to the health care of the people of Maine.

Information concerning other speakers at this year's WVSMA Annual Meeting will be published in upcoming issues of the *Journal*. A registration form for the meeting appears on page 95 and additional details can be obtained by phoning Nancie Divvens at (304) 925-0342.

FDA proposing to add folic acid to flour to help prevent birth defects

For the first time in 50 years, the FDA is proposing to fortify the nation's food supply for the good of public health. The proposal calls for adding the B vitamin folic acid to flour due to mounting evidence that folic acid, taken early in pregnancy, can prevent birth defects of the spine and brain (neural tube defects), such as spina bifida.

The FDA recently announced that manufacturers of vitamin supplements containing folic acid may rightfully claim its benefits. Approximately 2,500 babies are born with neural tube defects each year in this country; 500 die as a result. An estimated 50% of these defects could be prevented with adequate folic acid intake at the appropriate time during pregnancy.

Folic acid occurs naturally in foods such as leafy, green vegetables, some cereals and legumes, but, for many, it may be difficult to consume an adequate amount through a normal diet. Adding folic acid to the flour supply would help to ensure that more pregnant women get the folic acid they need. If the proposal is finalized this year, it would still be months before it would be implemented. Even then, some pregnant women may not consume enough flour products to get the recommended amount of folic acid.

To ensure adequate intake and thereby reduce the risk of neural tube defects, many physicians and groups such as the March of Dimes suggest that women who might possibly become pregnant eat a balanced diet and take a prenatal multivitamin/multimineral supplement containing folic acid every day. To educate the public and health care professionals about the importance of folic acid, the March of Dimes and Wyeth-Ayerst Laboratories are conducting a national campaign.

To obtain informational materials about this subject, contact the West Virginia Chapter of the March of Dimes at (304) 722-4255.

Dr. Carr named head physician of Summer Olympic Festival

Carr

Dr. Daniel Carr, an orthopedic surgeon at Scott Orthopedic Center, Inc. in Huntington, has been selected to be the head physician at the 1994 Summer Olympic Festival in St. Louis. His duties will include supervising all medical personnel and overseeing the treatment of all athletes.

Dr. Carr received his medical degree from the University of Vermont in 1980. He interned at the University of Utah from 1980-81 and then did a residency at the University of Vermont from 1981-85. Dr. Carr has been a member of the WVSMA and the Cabell County Medical Society since 1985.

Fifth Annual Rush Symposium set for Saturday, May 21

"Leflunomide: A New Direction in Immunosuppression" will be the topic of the Fifth Annual Rush Symposium on Transplantation, which is scheduled for Saturday, May 21 at Rush-Presbyterian-St. Luke's Medical Center in Chicago.

The rapidly advancing technology in anti-rejection therapy has lead to a new and promising direction in immunosuppressive drugs, specifically the novel drug Leflunomide. Leflunomide has many promising properties including its ability to prevent and reverse allograft rejection, to down-regulate alloantibody production and to provide exceptional control of concordant xeno rejection, placing it high among the small group of evolving drugs with potential for clinical transplantation. The symposium will feature a series of lectures describing Leflunomide's action in rodents and in dogs, its mechanism of action and its early expanse in human use.

For symposium details, call the Transplant Program Physician Relations Coordinator at (312) 942-6242.

Spirometry training course offered by ALA

The American Lung Association of West Virginia is once again offering its course in "Spirometry Training in Occupational Health" at John XXIII Pastoral Center in Charleston on April 27 and 28.

This course is designed for nurses, physicians, respiratory therapists and other health care providers involved in spirometry screening programs. It will focus on the use of screening spirometry for the evaluation of lung function in occupational health and other health care facilities. Lectures, small group sessions and hands-on experience ensure that each participant will meet the course objectives.

Karen B. Mulloy, D.O., M.S.C.H., is the spirometry course director. Dr. Mulloy is chief of the Division of Occupational and Environmental Health in the Department of Family and Community Health at the MU School of Medicine. Lecturers include Bipin H. Avashia, M.D., clinical associate professor of medicine at the WVU School of Medicine, Charleston Division; and John L. Hankinson, Ph.D., chief of the Clinical Investigations Branch of the Division of Respiratory Disease at the Appalachian Laboratory for Occupational Safety and Health.

The National Institute for Occupational Safety and Health (NIOSH) has given this training session Course Approval #026, and St. Francis Hospital has approved tit 16 CME contact hours.

There is a discount fee for registrations received by April 1 and for companies sending three or more employees. Enrollment is limited, so early registration is recommended.

For more information, call Shawn Harris Chillag at (304) 342-6600 or 1-800-LUNG-USA in WV.

Logan County Medical Alliance to host dinner for Doctor's Day

In honor of Doctor's Day, members of the Logan County Medical Alliance are hosting a dinner for physicians, auxilians and their families on March 30 at 6:30 p.m. in the Logan General Hospital Cafeteria. CME will be offered.

To RSVP, phone Siromani Bellam at 583-9353 or Trudy Tordilla at 583-6272.

Fifteenth Cape Cod Institute scheduled

The Fifteenth Annual Cape Cod Institute, sponsored by the Department of Psychiatry at the Albert Einstein College of Medicine, will consist of a summer-long series of postgraduate courses for professionals in mental health, health science, and applied behavioral science. Topics include psychodynamic therapy, behavioral medicine, brief therapy, humanistic psychology, psychological assessment, neuropsychology, family therapy, childhood and adolescence, and organizational development.

Sessions will be held weekday mornings June 27-September 2, from 9 a.m. until 12:15 p.m., leaving the afternoons free for leisure and study. Optional discussion groups and social gatherings are arranged, and Institute staff members provide abundant information about activities on Cape Cod.

A complete course catalogue may be obtained from: Cape Cod Institute, Albert Einstein College of Medicine, 1308A Belfer Building, Bronx, NY, 10461; (718) 430-2307.

Ninth Medicolegal Investigation of Death Seminar planned

The Ninth Medicolegal Investigation of Death Seminar is set for April 9 at the Robert C. Byrd Health Sciences Center of West Virginia University in Morgantown.

This seminar is sponsored by the Office of the Chief Medical Examiner of the North Central Region; the State of West Virginia; the West Virginia Deputy Sheriffs Association; the West Virginia State Lodge Fraternal Order of Police, the West Virginia Chiefs of Police Association, the West Virginia Troopers Association and the Department of Pathology at the West Virginia University School of Medicine.

For more details, phone Donna Golleher at (304) 293-5569.

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PHYSICIAN'S RECOGNITION AWARDS

We wish to congratulate the following WVSMA members who recently received Physician's Recognition Awards from the AMA for voluntarily completing 150 credit hours of continuing medical education during the past three years:

Brooke

Patsy P. Cipoletti, MD

Cabell

James R. Morris, MD
Jose I. Ricard, MD
Jack R. Steel, MD
Gerald E. Vanston, MD
Deleno H. Webb, MD

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Stephen R. Cirelli, MD
Moosa Kasmet, MD
Dwight A. Wagenknecht, MD

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Ray Lewis, MD
Joseph G. McCabe, MD
Edward L. Pinney, MD

Fayette

Arsenio P. Navarro, MD

Greenbrier

Steven B. Hefter, MD
Ronald R. Scobbo, MD

Harrison

Paul M. Brager, MD
John J. Crossen, MD
Chinmay K. Datta, MD
David R. Hess, MD
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Louis C. Palmer, MD

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Robert L. Smith, MD
Jeffrey A. Stead, MD
Harry L. Taylor, MD
Richard M. Vaglienti, MD
Stephen J. Wetmore, MD

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George E. Bontos, MD
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Paul R. Hedges, MD
Krishna R. Urval, MD
Jeffrey M. Yost, MD

Parkersburg Academy

Robert M. Biddle, MD
E. Samuel Guy, MD

Putnam

Alfonso P. Cinco, MD

Raleigh

Sung W. Chang, MD
William A. Scaring, MD
Syed A. Zahir, MD

Tygart's Valley

Fouad H. Abdalla, MD

Continuing Medical Education

Listed on this page are some of the upcoming CME programs which will be held in the state. Unless otherwise noted, the events are presented at the location under which they appear.

If you would like to have the CME programs offered by your institution or association for physicians printed in the *Journal* or obtain more details about the meetings listed, please contact Nancy Hill, managing editor, at 925-0342.

Marshall University School of Medicine - Huntington

March 21
"Polyreactive Antibody Molecules and Natural Immunity" (Research Day Opening Lecture), Abner Louis Notkins, M.D., 7 p.m., Marshall University Fine Arts Building

March 22
"7th Annual Research Day," 8 a.m., Holiday Inn Gateway-Convention Center, Barboursville

Raleigh County Medical Society - Beckley

March 22
"Update on Use of Anti-Inflammatory Drugs," Howard Feinberg, D.O., 6:30 p.m., Black Knight Country Club

March 24
"New Approaches to Community-Acquired Respiratory Infections," Samuel Pegram, M.D., 6:30 p.m., Black Knight Country Club

March 29
"Bedwetting," William F. Tarry, M.D., 6:30 p.m., Raleigh General Hospital

Robert C. Byrd Health Sciences Center of WVU - Charleston

March 24-25
"21st Annual Newborn Day: Metabolic Disorders of the Newborn"

April 7
"Obstetrical Update" (co-sponsored by the West Virginia Chapter of the American Academy of Family Physicians and CAMC), Huntington

April 7
(Teleconference) "Pregnancy-Induced Hypertension," Todd C. Resley, M.D.

April 19
"Mini and Maxi Flaps" (sponsored by The Eye and Ear Clinic of Charleston and the Dept. of Surgery), Ted Jackson, M.D., 4th Floor Faculty Lounge

April 21
(Teleconference) "Childbirth Education Update," Paula Vasale, R.N.C., B.S.N., C.E.S.

May 5
(Teleconference) "Respiratory Distress in the Newborn," Stefan R. Maxwell, M.D.

May 19
(Teleconference) "Blood Borne Pathogens: The Health Care Providers' Risk," Elizabeth A. Funk, M.D.

May 11-12
"3rd Annual Issues in Perinatal Health Care"

May 17
"Management of a Congenital Neck Mass" (sponsored by The Eye and Ear Clinic of Charleston and the Dept. of Surgery), R. Austin Wallace, M.D., F.A.C.S.

Robert C. Byrd Health Sciences Center of WVU - Morgantown

March 24-25
"WVU Urology Update" (sponsored by the WVU Dept. of Urology and the West Virginia Urological Society)

March 26-27
"Spring Meeting of the West Virginia Chapter of the American Academy of Pediatrics" (sponsored by the WVAAP and the WVU Dept. of Pediatrics), Morgantown

April 9
"9th Medicolegal Investigation of Death Seminar" (co-sponsored by the Office of the Chief Medical Examiner)

April 13-15
"Awareness to Action II" (co-sponsored by West Virginians for Fetal Alcohol Syndrome Action), Days Inn, Flatwoods

April 14-16
"Southern Group on Educational Affairs Spring Regional Meeting" (co-sponsored by the WVU School of Medicine, MU School of Medicine and the State of West Virginia), Marriott Hotel, Charleston

April 22-24
"West Virginia State Radiological Society Spring Meeting: Breast Care Update 1994 (sponsored by the WVU Dept. of Radiology and the West Virginia State Radiological Society), Lakeview Resort and Conference Center, Morgantown

April 30
"Current Concepts in Cancer Care for the Non-Oncologist" (co-sponsored with Monongalia General Hospital), Lakeview Resort and Conference Center, Morgantown

May 1-4
"Wellness Conference," Lakeview Resort and Conference Center, Morgantown

May 20
"Second Annual Stephen C. Rector Visiting Lectureship in Emergency Medicine" (sponsored by the WVU Dept. of Emergency Medicine)

West Virginia State Medical Association - Charleston

March 26
Marbury vs. Madison Loss Prevention Program - Wheeling

April 14
Office Personnel Workshop - Parkersburg

Outreach Programs

Key to Sponsors

★ *Robert C. Byrd Health Sciences Center of WVU, Morgantown*

☐ *CAMC/Robert C. Byrd Health Sciences Center of WVU, Charleston*

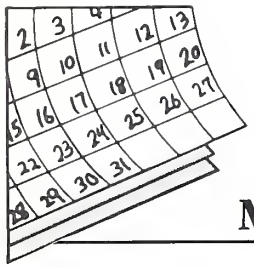
Gassaway ☐ Braxton County Memorial Hospital, March 23, 6:30 p.m., "Oncology Emergencies," Steven Jubelirer, M.D.

Oak Hill ☐ Plateau Medical Center, March 22, 6:30 p.m., "New Treatment for Fibrillation/Flutter," Ronald J. McCowan, M.D.

Parkersburg ★ Camden-Clark Memorial Hospital, March 23, 7 a.m., "Some New or Rediscovered Bacterial Pathogens"

★ Camden-Clark Memorial Hospital, March 30, 7 a.m., "The Impaired Professional"

Point Pleasant ☐ Pleasant Valley Hospital, March 24, noon, TBA



Medical Meetings

March

24-25–West Virginia Urological Society's Annual Spring Meeting, Morgantown

April

5-9–20th Annual Meeting of the Society for Biomaterials, Boston

8-9–Psychiatry Clinical Update: The Treatment Resistant Patient: Thick Chart Syndrome (sponsored by Ohio State University), Columbus

8-10–American Society for Contemporary Medicine and Surgery, Orlando, Fla.

8-10–42nd Annual Scientific Assembly of the West Virginia Chapter of the American Academy of Family Physicians, Huntington.

10-11–Planning Conference on Management Requirements for a National Implant Data System (sponsored by the Society for Biomaterials), Hyannis, Mass.

15-16–Gastroenterology Update: 1994 (sponsored by Ohio State University), Columbus

16-22–American Occupational Health Conference (sponsored by the American College of Occupational and Environmental Medicine), Chicago

21-24–American College of Physicians, Miami

21-24–47th Annual National Spring Meeting of the West Virginia Academy of Ophthalmology, White Sulphur Springs

28-30–Federation of State Medical Boards Annual Meeting, Washington, D.C.

29-30–Hypertension and the Kidney (sponsored by Ohio State University), Columbus

May

12-13–Building Blocks of Health Care Reform: Health Information and Quality Assessment (sponsored by AMPRA, Consumer Coalition, NAHDO and NBCH), Washington, D.C.

13-14–Topics in Radiology (sponsored by the University of Pittsburgh School of Medicine), Pittsburgh

13-15–Rheumatology and Allergy Update: 1994 (sponsored by Ohio State University), Mt. Sterling, Ohio

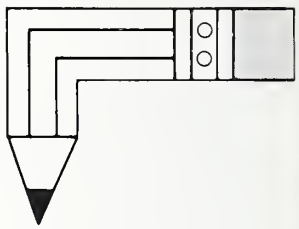
13-15–The Managed Care Revolution: Winning Strategies for Internists (sponsored by the American Society of Internal Medicine), Boston

18-20–47th Annual National Conference of the President's Committee on Employment of People With Disabilities, Atlanta

For More Information . . .

Contact the Journal at (304) 925-0342.

Poetry Corner



Snowy Vandalia

A light snow spread upon the ground
A lacy tablecloth laid down
With here and there the edge turned up
From frosted hill and dell and cup.

And there were clouds that rode the breeze
On silent scenes, where a twig or sneeze
Could snap and break the reverie
Marching time on snow topography.

Fuzzy fingers of snow outlined the branches
Like caribou antlers in rhythmic dances
For men by the fire; or, they're now "chandelier crystals"
To ladies, while the wind trails like minstrels.

Orbital gyrations of an atomic clock or star
Weighed out time to heal so far.
(Was there ever time to think and feel?)
I wouldn't doubt, where snow plopped in free fall,
(Breaking the crust beneath his heel)
That Bigfoot walked the Hills, at all.

Lee L. Neilan, M.D.

Please address your submissions for Poetry Corner to Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

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Department of Health & Human Resources

Bureau of Public Health News

This page of material is submitted and paid for by the Bureau of Public Health.

State's vital statistics released for 1992

The *1992 West Virginia Vital Statistics* has been released by the Bureau's Office of Epidemiology and Health Promotion. This report is compiled annually to detail births, deaths, marriages and divorces occurring among state residents.

The number of births in 1992 was 22,156, down from 22,509 in 1991. More than 27% of all births were to unwed mothers. Although the number of births to teenagers dropped to 3,809 in 1991, the percentage of births to unmarried teens increased from 55% in 1991 to 56.6% in 1992.

The percentage of low birthweight babies, those weighing less than 5 pounds, increased to 7.2% in 1992, up from 6.8% in 1991. Of all births in 1992, 26% were Cesarean section deliveries, and 77% of women giving birth in 1992 reported they received prenatal care during their first trimester of pregnancy, while nearly 27% smoked and 1.6% used alcohol during pregnancy.

The number of state deaths decreased in 1992 to 19,696, down from 19,951 in 1991. This established a death rate of 10.9 deaths per 1,000 people, and the average age of death was 68 years for men and 75 years for women.

For a copy of the report or for more information, contact the Health Statistics Center at (304) 558-9100.

Progress achieved in reaching health goals

A series of reports will monitor the state's efforts in accomplishing the goals in 21 health priority areas described in *West Virginia Healthy People 2000*, a report published in 1991 by the Bureau which lists specific objectives for the year 2000.

West Virginia Healthy People 2000 Updates look at disease trends and health behaviors, and predict the status of health conditions in 2000. The updates also identify policy initiatives implemented to meet goals. Ten of the 21 updates have been completed, addressing unintentional injuries, AIDS/HIV infection, tobacco use, physical activity, immunization and infectious diseases, heart disease and stroke, sexually transmitted diseases, diabetes, educational programs, and nutrition.

The goal of increasing the number of women who breastfeed has already been met, and if present trends continue, goals will be met to reduce death from fires and burns among preschoolers, reduce deaths due to heart disease, confine the prevalence of HIV infection, and limit the cases of gonorrhea. Headway is also being made in reducing deaths from falls among the elderly, lessening cigarette and smokeless tobacco use, increasing immunization levels, implementing programs to increase the detection, treatment and management of diabetes and its complications, reducing death from strokes, establishing projects to increase daily consumption of fruits and vegetables, and reducing the prevalence of hypertension.

Unfortunately, increases are being seen in the rates of motor vehicle deaths among children, the number of diagnosed AIDS cases, syphilis rates, and the prevalence of sedentary lifestyle and of obesity. To change these trends, 32 community health promotion sites have been established, 10 counties are participating in healthy schools projects, and several public and private worksite wellness programs have been implemented.

Future updates will address alcohol and other drugs, family planning, mental health, violent and abusive behavior, occupational safety and health, environmental safety and health, food and drug safety, oral health, maternal and child health, cancer, clinical preventive services, and data systems. When all the updates are compiled, objectives will be reviewed and adjusted as needed.

For a copy of the updates or for more details, contact the Healthy People 2000 Project Director Tom Sims at (304) 558-0644.

Surveyors complete qualifications test

The Bureau's Office of Health Facility Licensure and Certification (OHFLAC) reports that all its employees who survey long-term care (LTC) facilities have successfully completed the Surveyor Minimum Qualifications Test (SMQT). The OHFLAC now has 31 individuals who have passed the test, and West Virginia is one of only 16 states nationwide in which all surveyors have successfully completed the SMQT.

The OHFLAC is the office within the Bureau of Public Health responsible for licensure and certification compliance surveys in accordance with state and federal regulations. LTC certification qualifies eligible beneficiaries to receive services funded by Medicare and Medicaid.

In 1987, Congress enacted an extensive reform of LTC affecting the provision of nursing home services as part of the Omnibus Budget Reconciliation Act (OBRA 87). Among the mandates outlined in this rule was the requirement for all LTC surveyors to meet minimum qualifications. The Health Care Financing Administration (HCFA) responded to this mandate by developing the SMQT. Successful completion of the training and testing program identifies individuals who possess the minimum knowledge, skills and abilities necessary for LTC facility surveys, integral components of surveyors' on-the-job performance.

The test is comprised of two modules. Module A is designed for all LTC surveyors and tests their ability to evaluate residents' rights and the environment in which the nursing home resident lives. Module B is designed for those who perform reviews related to quality of care, testing their clinical judgement relative to nutrition, medication, resident assessments and nursing care.

As of February 1, no individual may conduct an independent survey of a LTC care facility unless the necessary modules have been successfully completed.

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ROBERT C. BYRD HEALTH SCIENCES CENTER
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Compiled from material furnished by the Robert C. Byrd Health Sciences Center of West Virginia University, Communications Division, Morgantown

First neuroradiology consult airs on MDTV

The first Mountaineer Doctor Television (MDTV) neuroradiology consult was conducted in December by Dr. Jeffery P. Hogg, who assisted an emergency room physician at Davis Memorial Hospital in Elkins.

"Although the ER physician had some exposure to radiological imaging, he wanted to base his treatment and diagnosis decisions on sharing the films and the patient's mode of presentation with someone who had a greater depth and breadth of training in neuroradiology," says Dr. Hogg, associate professor of radiology/neurology. "By using the MDTV system, the doctor didn't have to mail the film of the CT scan and have a two or three day delay. The patient was there, the films were there, and, through MDTV, I was there looking at the films on the viewbox."

MDTV allows physicians in outlying areas of the state to consult with specialists at the Robert C. Byrd Health Sciences Center.

Khakoo receives ACP's Laureate Award

Khakoo

Dr. Rashida A. Khakoo, professor and interim chair of the Department of Medicine, has received a Laureate Award from the West Virginia Chapter of the American College of Physicians (ACP).

Laureate Awards are presented to fellows of the ACP who demonstrate a commitment to excellence in medical care, education or research, and in service to their communities and ACP. Dr. Khakoo was given this honor at the ACP's Annual Scientific Meeting in Morgantown.

Smith appointed to national task force

Smith

Lee B. Smith, M.D., J.D., a clinical instructor of emergency medicine, has been appointed to serve as the only doctor on the national Tort Reform Task Force.

The task force is charged with reviewing the tort reform provisions of the National Health Security Act and relaying recommendations to the White House and Congress.

Neurology faculty serve as examiners

Several Department of Neurology faculty members served as examiners at the Part II Oral Examination of the American Board of Psychiatry and Neurology, which was conducted January 9-11 in Baltimore, Md.

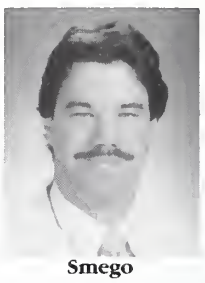
The faculty participating were Dr. Ludwig Gutmann, professor and chair; Dr. Jim Martin, professor; Dr. John Bodensteiner, professor and section chief of pediatric neurology; Dr. Alvaro Gutierrez, assistant professor and director of the Neurophysiology Lab; Dr. Bob Keefover, associate professor and director of the Neuropsychiatry Program; and Dr. Laurie Gutmann, assistant professor and medical director of the EMG Lab.

Timberlake, Stewart earn national honors

Two Department of Surgery faculty members have received national honors.

Dr. Gregory A. Timberlake, associate professor, was appointed to the American College of Surgeon's Committee on Trauma; and Dr. Daniel Stewart, assistant professor of plastic and reconstructive surgery, was certified by the American Board of Plastic Surgery.

Smego speaks at international meeting



Smego

Raymond A. Smego Jr., M.D., M.P.H., associate professor of infectious diseases, and director of the International Health Program, was a speaker and symposium leader at the 15th International Conference on Medical Education for the Christian Medical and Dental Society in Kenya.

Dr. Smego's topics included multidrug-resistant tuberculosis, global antimicrobial drug resistance patterns, national HIV/AIDS control and management strategies, essentials of a third-world hospital formulary, and WHO-targeted disease eradication.

Interim director of trauma center named

Dr. Laurel Omert has been named interim director of the Jon Michael Moore Trauma Center. Dr. Omert is assistant professor of trauma in the Department of Surgery.

"The Department of Surgery and the trauma center are most fortunate to have the services of a surgeon of Dr. Omert's caliber and background," Dr. Gordon F. Murray, professor and chair of surgery said. "Dr. Omert served with distinction as interim director during Desert Storm, and she is certified by the American Board of Surgery with qualification in critical care."

Three new faculty members announced

The Department of Microbiology/ Immunology has announced the appointment of three new faculty.

William R. McCleary, Ph.D, assistant professor, is from Princeton University; and Meenal Elliott, Ph.D., assistant professor, and Thomas Elliott, Ph.D., professor, are from the University of Alabama in Birmingham.

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Formerly, Mr. Vannoy served as Associate General Counsel for the Health Sciences Center for WVU, including the School of Medicine. Daniel has enjoyed providing legal advice, counsel and representation to physicians at WVU.

Daniel Vannoy invites physicians and other health care practitioners throughout West Virginia to contact Vannoy Law Offices for quality legal services. Mr. Vannoy encourages physicians with business, hospital affairs, legal and/or regulatory concerns to retain legal counsel early before those concerns develop into crisis.

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Marshall University School of Medicine

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington

Students enthusiastic about Rural Physician Associate Program

RPAP student Rodney Sirk examines a young patient at the Lincoln Primary Care Center.

(Marshall University photo by Rick Haye)

Marshall's Rural Physician Associate Program, now in its fourth year, continues to capture the imaginations of medical students and rural preceptors, reports Dr. Linda Savory, the program's director.

RPAP, adapted from its namesake at the University of Minnesota, allows selected medical students to spend six to nine months of their third year assigned to physicians at rural primary care sites. Students have responded enthusiastically to the program's hands-on emphasis.

"They are expected to carry the ball as far as they safely can, and, like most students, they rise to unexpected levels of competence," Dr. Savory said. "Rural preceptors report satisfaction from student contact, and many become actively involved in helping to shape the medical curriculum," she added.

In evaluating their experiences in Milton, Wayne, Spencer and Scarbro, students made the following comments:

"I felt as if I would have more control of my education in the RPAP program. I have found the program to be one of the most rewarding experiences of my medical education. I did indeed feel that I got a far superior education to my colleagues who went through the traditional program. I have also been responsible for a core of my own patients for nine months."

"I realized how much I was in the real world of medicine when I entered my first examining room to a 2-week-old infant and my second to a 96-year-old great-grandfather. My initial thought was, 'How can I schedule my patients in age-ascending order?' Then I realized - - this is family medicine is all about. Scary? You better believe it was. But, as time went on and the nervousness subsided, I could feel a certain bonding towards these patients and their families taking effect."

"I had a caseload of patients who I followed on a regular basis. When their lab work came back, I evaluated this and made recommendations for changes in therapy if indicated. In addition, I was responsible for handling any problems which occurred between appointments. When patients were admitted to the hospital, I was given the responsibility to assess their problems, plan the appropriate treatment and write the hospital orders."

"I was able to work with many different specialists while at the [rural] hospital, including several family physicians, two general internists, a nephrologist, a gastroenterologist, two general surgeons and an orthopaedic surgeon. In addition, I also had consultations with specialists in infectious diseases, hematology/ oncology and ENT. On many occasions, these specialists would catch me in the hospital, introduce me to patients with interesting problems, and let me follow their care while they were in the hospital."

"The program also provided the ability to follow patients over a period of time, and thus to assess treatment responses . . . For example, I saw a 75-year-old female that we diagnosed with diabetes mellitus. We initially placed her on oral hypoglycemics. However, as we were unable to control her blood sugars, we had to place her on insulin. It has taken nine months for her to achieve a stable level of diabetes control. It was quite gratifying to see her in the office a few days ago and see the progress she has made (actually the progress we both have made!)"

"Today I can say that participating in RPAP was the best educational decision I have ever made.... I have seen real-life primary care."

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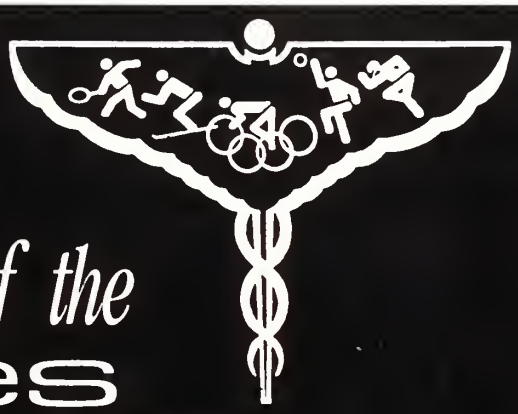

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Obituaries

J. D. Mathias, M.D.

Dr. J. D. Mathias, M.D., 72, of Wardensville, died January 4 at Life Care Center of New Market.

Dr. Mathias was born July 26, 1920, in Mathias, W.Va. He was retired from his general practice in Wardensville. In addition to being a member of the WVSMA, Dr. Mathias was a member of the AMA and South Branch Medical Society.

A veteran of the U.S. Army Medical Corps, Dr. Mathias was a member of the Wardensville United Methodist Church.

Dr. Mathias was the husband of the late Nellie Maxine Mathias. Surviving are two sons, Jay Mathias and James D. Mathias II, both of Wardensville; a brother, Owen Miller of Wardensville; two sisters, Andry Mathias and Ann Morgan, both of Oak Ridge, Tenn.; and three grandchildren.

Memorial contributions may be made to the Capon Valley Fire Company or the Wardensville Rescue Squad.

Estelito Santos, M.D.

Dr. Estelito Santos, M.D., 56, of Huntington, died February 12 at Greenbrier Valley Medical Center.

Dr. Santos was born in Manila, Philippines, and received his medical degree from the Far Eastern University Institute of Medicine. He interned at North General Hospital and completed an ob/gyn residency at Rizal Provincial Training Hospital.

Dr. Santos was president of Emergi-Care Inc. Prior to this, he was an emergency room physician at Cabell Huntington Hospital for 13 years, where he served as medical director for five years. During his career, Dr. Santos had also been a physician at Huntington State Hospital.

In addition to being a member of the WVSMA and the Cabell County Medical Society, Dr. Santos was a member of the Philippines Medical Society and the Tri State Fil-Am Association of West Virginia, Ohio and Kentucky He was also a member of Our Lady of Fatima Church.

An avid golfer, Dr. Santos had attained numerous awards and had chaired the golf tournament at the WVSMA's Annual Meeting for the past several years.

Survivors include his wife, Corazon Moreno Santos; two sons, Estelito M. Santos Jr. and Jose M. Santos, both at home; one daughter, Lisa M. Santos, at home; four brothers and one sister.

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Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

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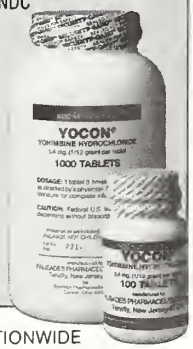
References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



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Front Cover

Venus's Looking Glass, a plant of the Lobelia Family, blooming in a remote area of Kanawha County. Photo courtesy of *Ron Snow,* State of West Virginia, Division of Natural Resources.

Feature Article

The Health Care Quality Improvement Program: The WVMI returns to its founding mission

HARRY S. WEEKS JR., M.D.
President and Medical Director of the West Virginia Medical Institute, Charleston; and Anesthesiologist, Wheeling.

Editor's Note: *Dr. Weeks also served as president of the West Virginia State Medical Association from 1971-72.*

Abstract

The Health Care Financing Administration (HCFA) has launched an ambitious new program for Peer Review Organizations (PROs) called the Health Care Quality Improvement Program (HCQIP). The goal of HCQIP is to improve the quality of care for all Medicare beneficiaries through cooperative interaction between PROs, providers, and physicians. The West Virginia Medical Institute, which serves as the PRO for West Virginia and Delaware, has recently begun to implement the changes required by HCQIP. This article explains the various approaches WVMI will use to achieve the health care improvement goals set forth by HCFA.

Introduction

I am reminded of that old saying "The more things change, the more they stay the same," when I think of how our physician education and peer review mission has literally come full circle during my 22 years with the West Virginia Medical Institute (WVMI).

When I joined WVMI in 1972, the organization functioned primarily as the educational arm of the West Virginia State Medical Association. In 1984, we were awarded our first contract from the Health Care Financing Administration (HCFA) to serve as the Peer Review Organization (PRO) for West Virginia, and then in 1986, we were awarded the PRO contract for Delaware as well.

During the first three PRO contract cycles or "Scopes of Work" (1984-93), WVMI's focus gradually shifted away from educating the medical community as a whole toward addressing individual quality, utilization, and Diagnostic Related Group (DRG) concerns relating to the Prospective Payment System. Under the current Scope of Work, HCFA has directed the PROs to move toward identifying practice patterns that can lead to comprehensive improvements for the entire Medicare population. This "new" educational approach, known as the Health Care Quality Improvement Program (HCQIP), signals a profound shift in HCFA's approach to peer review.

Defining the HCQIP

In short, HCQIP is an effort to shift the focus of the PROs from identifying individual episodes of substandard care to identifying patterns that can result in widespread improvements for all patients. Under HCQIP, WVMI will identify providers with the best practice patterns, and share this information with other providers to help them better focus their educational efforts and improve their outcomes.

This new approach has brought about a dramatic change in peer review methods and affected the entire scope of WVMI's activities. Nonetheless, we welcome HCFA's shift in philosophy and believe the health care community will do the same.

Cooperative projects

WVMI will study patterns of care and outcomes through national cooperative projects such as the Medical Hospital Information Project (MHIP) and the Cooperative Cardiovascular Project (CCP), as well as through locally-developed projects. The national projects will be developed by representatives from HCFA, the Public Health Service, PROs, health care providers, and consumers. Each project will have a specific clinical focus.

MHIP and CCP are the first two national projects that will be implemented. MHIP will use information on hospital mortality rates to target opportunities for significant care improvements. CCP will analyze critical data on Medicare patients hospitalized for heart attacks, bypass surgery, and angioplasty. In addition, the American College of Cardiology's practice guidelines will be used to analyze patterns in the care of acute myocardial infarction.

WVMI will also develop a number of local cooperative projects targeted toward variations in care throughout West Virginia and Delaware. The sources of data for these local projects will include MEDPRO, which is a HCFA-maintained file containing post-payment information on all inpatient Medicare claims, and WVMI's own case review data. WVMI has a number of local projects underway including studies of the use and timing of pre-operative antibiotics; the length of stay for open and laparascopic cholycystectomies; sepsis coding; blood transfusions; and community-acquired pneumonia.

As part of the cooperative project process, WVMI will select cases and look only at the issues for which the cases have been selected. Project data collection (formerly called "focused review") will now be a cooperative, fact-finding effort with providers.

Educational feedback

Information about patterns of care will be fed back to individual providers, and, in aggregate form, to Medicare beneficiaries and the medical community as a whole. The data will come from pattern or case review analyses at both the provider and statewide levels.

HCQIP places greater emphasis on cooperative interaction between PROs, physicians, hospitals, and medical staffs. As part of this cooperative effort, WVMI's Principal Clinical

Coordinator Dr. Mark Stephens will provide individual hospital feedback to each facility's administrative and medical staffs. When a pattern of concern requiring physician feedback is identified, WVMI will work cooperatively with the hospital(s) to improve this pattern. The hospital(s) will be asked to seek the underlying factors, outline specific actions to improve those patterns, and verify that improvement has occurred.

WVMI will provide statewide feedback through regular meetings with hospitals and medical associations, informational newsletters, regional seminars, or in other educational settings.

Case review

WVMI will continue to review hospital care and ambulatory surgery for quality, utilization, appropriateness of setting and validation of DRGs. Contrary to past practice, review will be done on a selected sample of beneficiaries rather than a sample of cases from selected facilities.

As in the past, all beneficiary complaints, and, on request, all hospital-issued notices of non-coverage will be reviewed. To more effectively target educational activities, WVMI will also profile all reviewed cases by physician, by provider, and for the entire state.

Other important changes

Other critical changes are as follows:

- The Quality Intervention Plan has been eliminated. Hospitals and physicians will no longer be assigned "points" when quality problems are identified.
- The quality review process has changed. WVMI will use an educational approach to address patterns and documentation issues. Preliminary notices of potential quality concerns will be less confrontational and will be sent to the hospital as well as the attending physician. WVMI will send notices of final determinations to physicians and providers in all cases, regardless of the outcome. Physicians and hospitals may ask for re-reviews of final determinations on quality issues.
- Pre-procedure review will be required only for an assistant at cataract surgery for specific codes.
- WVMI will coordinate with the State Medical Board and other certification and accreditation bodies to discuss information sharing and to execute formal written agreements to assure the exchange of specific data.

Conclusion

As a practicing physician and longtime advocate of medical peer review, I am heartened to see the WVMI returning to its roots -- educating the medical community and enhancing the quality of care provided to all patients.

I hope that physicians and providers throughout West Virginia will share our enthusiasm for the new cooperative, educational approach to Medicare peer review, and support us in this significant health improvement initiative.

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The value of prostatic specific antigen in prostate cancer screening in the community

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Abstract

At a one-day screening for prostate cancer in 1991, a urologist evaluated 142 men ages 50 years-84 years (mean: 67 years) utilizing a digital rectal exam (DRE), serum prostatic specific antigen (PSA), and a detailed questionnaire. The 44 men with an abnormal DRE and/or PSA were recontacted by letter one year later to determine the outcome. By 12 months, 31 men (70%) with abnormal findings had seen a physician as recommended. Of the 13 men followed with abnormal DRE only, three were biopsied with no cancer found. Of the 11 with an elevated PSA only, six were biopsied and two had cancer. Of the men with both abnormal PSA and DRE, six were biopsied and two had cancer. Thus, after 12 months, the preliminary cancer detection rate was 2.8% for the entire study population, 22% for those with an elevated PSA, and 10% for those with an abnormal DRE. The results suggest that the use of PSA combined with DRE is a more efficient strategy for detecting prostate cancer than DRE alone.

Introduction

Adenocarcinoma of the prostate is the most common cancer in men, representing 22% of all cancers and 12% of all male cancer deaths (1). Approximately 65 percent of prostate cancers are clinically localized at the time of diagnosis (2), but only about half of these prove to be confined to the prostate at the time of surgery (3). Thus, nearly two-thirds of cancers have spread beyond the prostate when first identified.

Prostatic specific antigen (PSA) is a serine protease secreted exclusively by prostatic epithelial cells (4). Elevated serum levels of PSA have been noted in 30%-50% of patients with benign prostatic hyperplasia, and in 25%-92% of patients with prostate cancer, depending on tumor volume (5-7). Measurement of serum PSA is the most sensitive marker available for monitoring the progression of prostate cancer and the response to therapy (5-8). The value of measuring serum PSA in addition to the digital rectal examination (DRE) and transrectal ultrasound (TRUS) has not received attention until recently (9).

Measurements of serum PSA concentration offer several theoretical advantages over rectal examination or TRUS in prostate cancer screening. The result is objective, quantitative, obtainable independently of the examiner's skill, and from the patient's point of view, preferable to DRE or TRUS.

This article describes the preliminary results of the use of the PSA in prostate cancer screening at the Charleston Area Medical Center (CAMC).

Methods and materials

During a one-day screening for prostate cancer in April 1991, 142 men were evaluated. Participants were initially asked to fill out a detailed questionnaire. Information requested included the participant's age, race, time since last visit to a physician, time since the last rectal examination, educational level, urinary complaints, history of smoking or drinking, family history of prostate cancer, and prior history of prostate surgery or prostatitis.

Blood was then drawn for PSA determination and a DRE was performed by a urologist. The PSA was determined using the Tandem-R (Hybritech, San Diego, Calif.) assay with 4.0 ng./ml. being utilized as the upper limit of normal. Those participants with either an abnormal DRE (i.e. asymmetry, induration, or a nodule) or serum PSA greater than 4 ng./ml. were referred to their own urologist or personal physician for diagnostic procedures or treatment. Names of local physicians were offered for individuals without a urologist or personal physician.

Approximately one year after the screening, letters were sent to all clinically positive participants requesting details about their follow-up and results of treatment. These persons were asked whether they had seen a physician in follow-up, the results of the biopsy if performed, and the nature of any treatment. Letters requesting similar information were also sent to the patients' treating physicians. Self-addressed, stamped envelopes were included to encourage a response.

Results

There were 142 participants in this screening. Ninety-seven percent were Caucasian and 3% were black. Most of these men were well-educated (32% graduated high school and 37% had attended college). Their median age was 67 years (range 50 years-84 years). The percent age distribution for the screened participants was: 50-59 (20%); 60-60 (40%); 70-79 (36%); and ≥ 80 years (4%).

The results from the questionnaire are shown in Table 1 and indicate that 23% of participants never had a DRE, and that only 30% had undergone a

TABLE 1. RESULTS OF PATIENT QUESTIONNAIRE

1.	**Last Physician Exam**		4.	**Symptoms**	
	< 1 year	44%		Nocturia	60%
	1-2 years	21%		Weak Urine Stream	40%
	2-5 years	18%		Dysuria	13%
	> 5 years	11%		Bone Pain	4%
	Never	3.5%		Pyuria	1.5%
	Don't Know	2.5%		Blood in Semen	0.7%
2.	**Last Rectal Exam**		5.	**Family History of Prostate Cancer**	
	< 1 year	30%			13%
	1-2 years	16%			
	2-5 years	16%			
	> 5 years	15%			
	Never	23%			
3.	**Level of Education**		6.	**Medical History**	
	< 8th Grade	10.5%		Prior Prostate Surgery	10%
	Some High School	18%		Enlarged Prostate	30%
	High School Grad	32%		Prostatitis	12.5%
	Technical School	2.5%			
	Some College	16%			
	College Grad	10%			
	Post Grad	11%			

TABLE 2. RESULTS OF FOLLOW-UP OF MEN WITH ABNORMAL FINDINGS

	Number of Patients	Number Biopsied	Number With Cancer
Elevated PSA Abnormal DRE	7	6	2
Elevated PSA Normal DRE	11	6	2
Normal PSA Abnormal DRE	13	3	-

PSA = Prostatic Specific Antigen
DRE = Digital Rectal Examination

TABLE 3. CLINICAL DETAILS OF MEN WITH PROSTATE CANCER

	AGE	PSA Ng./Ml.	DRE	STAGE (Pathological)	TREATMENT
1	73	22.8	Normal	B_1	RP
2	78	7.2	Abnormal	B_2	RP
3	60	11.0	Abnormal	B_1	RP
4	77	5.0	Normal	C	Radioactive Seeds

RP = Radical Prostatectomy

TABLE 4. RECENT POPULATION STUDIES OF PROSTATE CANCER SCREENINGS USING PSA

Reference	Number of Men	0-4.0 Ng./Ml.	>4-10.0 Ng./Ml.	710.0 Ng./Ml.	Detection Rate
ACS-NPCDP[10]	2,229	85.3	11.3	3.4	2.4%
Brawer et al[11]	1,249	85.0	11.9	3.0	2.6%
Catalona et al[12]	1,653	91.7	6.5	1.8	2.2%
Labrie et al[14]	1,002	87.6	8.9	3.5	5.7%
Cooner et al[13]	1,807	66.7	20.3	13.0	14.6%
Present Study	142	86.0	12.0	1.4	2.8%

DRE within the previous 12 months. However, 65% of the participants had seen a physician within the previous two years.

Nocturia and a weak urinary stream were the most common symptoms encountered (60% and 40% of participants, respectively). Overall, 30% of these men had a history of benign prostatic hyperplasia and 10% had undergone prostate surgery. No participant was known to have had prostate cancer previously, but 13% indicated a family history of prostate cancer.

Of all the men tested, 44 (30%) had suspicious findings (i.e. abnormal DRE and/or elevated PSA). There were 25 men (17%) with an abnormal DRE only, 12 (8%) with an abnormal PSA only, and seven (5%) with both an abnormal DRE and PSA. By 12 months, 31 (70%) of these men had seen a physician as recommended, but six refused follow-up and no information was available for seven of them.

The results of follow-up are shown in Table 2. Three of the men with an abnormal DRE were biopsied and no cancer was found. Of the 11 participants with an elevated PSA only, six underwent prostatic biopsy and two had cancer. In addition, of the seven participants with both an abnormal PSA and DRE, six were biopsied and two had cancer. Thus, after 12 months, the preliminary cancer detection rate was 2.8% (four of 142) for the entire study population. The detection rate for those with an elevated PSA and for those with an abnormal DRE was 22% (four of 18) and 10% (two of 20) respectively.

Subsequently, three of the four men with prostate cancer underwent radical prostatectomy and one received radioactive I-131 seeds (Table 3). Three men had organ-confined disease as determined by pathological examination.

Discussion

The preliminary overall cancer detection rate of 2.8% in the screening using both PSA and DRE is in accordance with other published studies (Table 4)(10-14). In contrast, the cancer detection rate in several large studies of prostate cancer screening using DRE alone has ranged from 0.8% to 2.7% (9). With the exception of the study by Cooner and his colleagues, the results reported in Table 4 involved men not under evaluation for urological complaints (13).

All of these five studies focused on men at ages when prostate cancer risk is significant, but some difference in age distribution may account for differences in cancer findings and PSA distribution. The study by Labrie et al (14) yielded a higher cancer detection rate, possibly because biopsies were recommended when the PSA exceeded 3.0 ng./ml. and this is a more sensitive threshold than the 4.0 ng./ml. criterion used in the other investigations.

It is clear that the serum PSA was more sensitive than DRE in detecting prostate cancer. All patients with cancer in our screening had elevated levels of serum PSA, whereas only two had an abnormal DRE. It is impossible to assess the sensitivity and specificity of the screening methods used since the true prevalence of prostate cancer in our population was not known. Careful follow-up of these men over many years may provide the necessary data.

Three of the four cancers detected in this screening were pathologically confined to the prostate. Recent PSA screening studies (10-14) have indicated that 60%-65% of prostate cancers detected are [pathologically] organ-confined. In the most recent update of the screening program (1989-92) for Prostate Cancer Awareness Week (PCAW), Crawford et al (15) reported that less than 15% and 10% of cancers detected were stage C and stage D respectively. However, due to the limited data available at this time, it remains impossible to predict whether or not those cancers detected by screening would have caused symptoms or even death if they had been left untreated.

Several studies have addressed the problem of the natural history of localized prostate cancer (16,17). These studies have shown that the two most important factors in predicting the behavior of a localized prostate cancer are the volume and histological grade of the tumor. Although these factors are important when groups of patients are studied, it remains impossible to predict with any accuracy the chances of local progression or metastatic spread of any individual cancer.

Several aspects about the interpretation of our data are important. First of all, our data provides little evidence of benefit to the participants. Our results, as well as those from other published studies, provide no information about the value of screening in reducing prostate cancer morbidity and mortality.

Secondly, the group of men examined represent a self-selected population. The majority of participants were Caucasian, had seen a physician in the past two years, were high school or college graduates, and had some urinary symptoms. These findings mirror the broader national subjects that have participated in the PCAW screenings since 1989 (15). The Prostate Cancer Education Council has found that these self-selected populations are overwhelmingly Caucasian, more highly educated than the national average, have regular health check-ups, and may have been prompted to participate in prostate cancer screening by some urologic symptoms. We have no information on persons who chose not to participate in our screening. Since volunteer populations may not completely reflect the characteristics of the population of men at risk of prostate cancer, we are limited in our generalization of these findings beyond the group studied.

In addition, our data provided little insight concerning the cost-effectiveness of screening for prostate cancer. This is an issue that was addressed in a study by Littrup and colleagues (18), which suggests that, economically at present, the combination of DRE and PSA at 4 ng./ml. provides the best approach to potentially decrease prostate cancer mortality. Although our screenings were conducted with little or no direct cost to the participants, the aggregate value of the health services involved is substantial and is a subject for further study.

Despite the limitations of our study which I have descibed, our data adds to the increasing evidence that DRE alone can no longer be considered the sole means of detecting prostate cancer. Although the serum PSA is an imperfect screening test, when combined with DRE, it increases the rate of detection of prostate cancer.

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Idiopathic long q-t syndrome: Brief case report and discussion

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Abstract

Idiopathic long q-t syndrome (LQTS) is an infrequently occurring familial disorder in which affected family members have an abnormally prolonged q-tc interval with syncope, ventricular arrythmias and sudden death. In this article, we present the case of a 54-year-old female admitted for syncope, who was on no medications except for insulin. Her electrocardiogram on admission had prolonged q-tc interval (0.50 ms.). She had repeated episodes of torsades de pointes during her hospitalization, which were later controlled by beta-blockers. Electrocardiograms of her mother and daughter showed asymptomatic prolonged q-tc interval. This syndrome has an autosomal dominant pattern of transmission and it was first described by Romano and Ward in a patient with normal hearing. Our case is unusual because this condition presented so late in life.

Introduction

The q-t interval in an electrocardiogram is a readily available index of the time required for ventricular activation and recovery of excitability. The upper limit for q-t interval when corrected for heart rate by Bazett's formula (1) is 0.44 ms. The phenomenon of delayed repolarization causing prolongation of the q-t interval is categorized into idiopathic long q-t syndrome (LQTS) and acquired types.

The idiopathic form has strong familial patterns suggesting genetic mechanism of inheritance. About 10% of the reported cases are of the sporadic non-familial type. The heritable form has been mostly noted in the age group of infants to young adolescents.

This article presents the first reported case of LQTS where the patient remained asymptomatic until her fifth decade of life, which is unusual.

Case report

A 54-year-old black female with a history of syncope was admitted to Ohio Valley Medical Center after leaving an emotional church sermon. Before this event, she had described a feeling of palpitations.

This patient had normal hearing and her past medical history revealed that she had experienced recurrent dizziness without loss of conciousness within the past three years, as well as diabetes mellitus which required insulin. She had also been diagnosed with non-Hodgkins lymphoma in 1991.

Electrocardiogram showed prolonged q-t interval (q-tc 0.50 ms.). A large retroperitoneal mass along with some enlarged lymph nodes in the neck were noted. Serum electrolytes and a CT scan of the brain were normal. Echocardiogram showed mild left atrial enlargement and normal ejection fraction of the left ventricle. Also, intracardiac masses were excluded and valve motion was normal.

This patient developed recurrent episodes of torsades de pointes (Figure 1) and ventricular tachycardia during her hospitalization, which were finally controlled with intravenous magnesium and bretylium. Serial electrocardiograms showed persistent prolonged q-t interval and she was discharged home on oral propranolol.

During follow-up as an outpatient, her q-t interval was noted to be borderline prolonged (q-t 0.45 s.). Electrocardiograms of the mother and daughter showed borderline prolonged q-t intervals (q-tc 0.45 ms.).

Discussion

LQTS was first described in 1957 by Jervell and Lange-Nielsen (2). Their case involved a Norwegian family where four of the six siblings had congenital deafness, syncope and

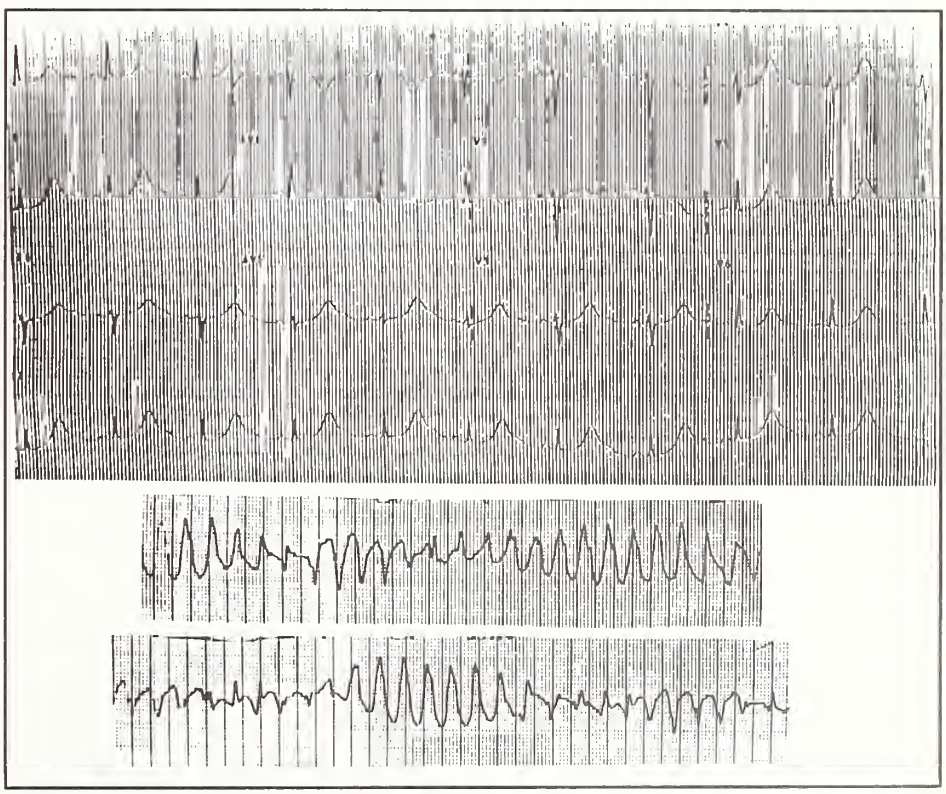

Figure 1. Admission electrocardiogram of the patient at rest demonstrating the prolonged q-t interval. Rhythm strips show torsades de pointes in the same patient in the cardiac care unit.

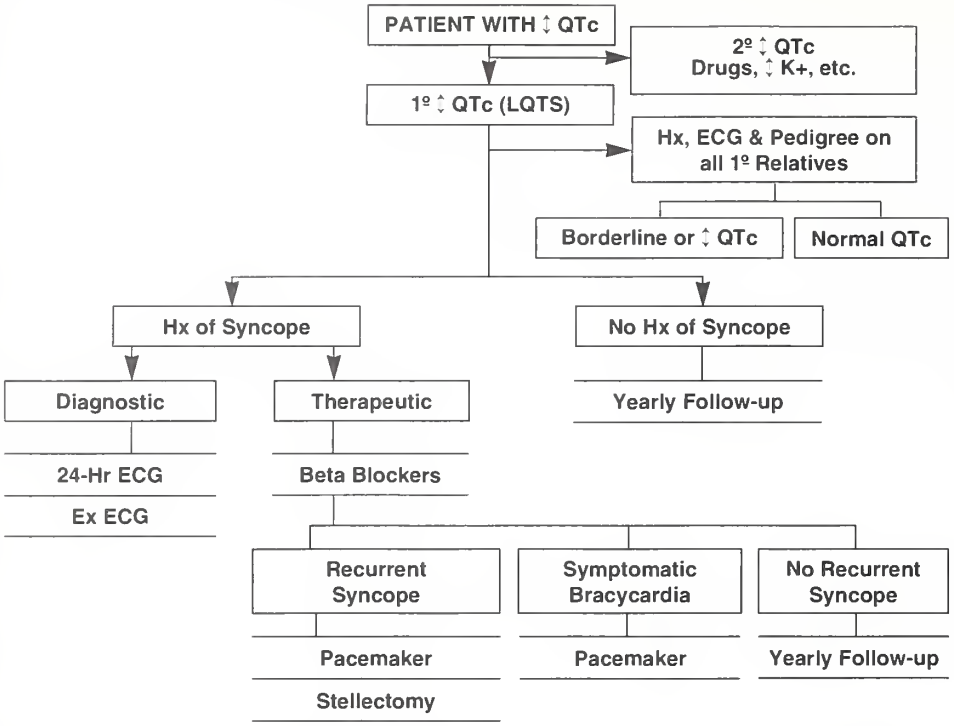

Figure 2. Algorithm for managing patients identified as having long q-t syndrome (LQTS). [Increase, Decrease, HX, History, ECG, Electrocardiogram].

sudden deaths, and several similar cases were later reported. All of the patients in these cases had severe bilateral high-frequency deafness and structurally normal hearts.

This type of LQTS is considered to have an autosomal recessive form of inheritance with pleiotropic expression of the gene. The heterozygote is either clinically normal or has asymptomatic slight prolongation of the q-t interval.

In 1963, Ward (3) described a case of syncope associated with prolonged q-t interval, ventricular arrythmias and sudden death, but normal hearing. Numerous cases have since been described in literature and an autosomal dominant pattern of inheritance has been proposed. In 1979, a worldwide prospective registry of patients with LQTS was established for follow-up and to evaluate the efficiency of therapeutic interventions (4).

The clinical hallmarks of this condition are recurrent syncope, prolonged q-tc interval, family history of sudden deaths or syncope. Syncope has been known to be preciptated by intense emotions such as anger or fright, intense physical activity and occasionally with auditory stimuli. Frequently patients with long q-t syndrome have resting bradycardia, and exercise testing has revealed either failure of the q-t interval to shorten during exercise or exaggerated q-t prolongation in the recovery phase after exercise (5).

Holter monitoring of patients with history of syncope and prolonged q-t interval, has often revealed episodes of bradycardia, transient ventricular arrythmias and episodic t-wave alternans characteristic of this disorder.

Patients of all ages presenting with abrupt syncope, especially children, should have an electrocardiogram obtained and a careful family history of recurrent syncope or premature sudden death recorded. If positive family history of sudden death exists, then electrocardiograms of first degree relatives should be obtained. The risk of sudden death in patients with LQTS and unexplained syncope is about 5% a year. It is difficult, however, to predict which patients with an initial episode of transient ventricular arrythmias will go on to have a fatal outcome. Data collected thus far suggests that the highest mortality rates are found in individuals with electrocardiographic t-wave alternans, or those with a prolonged q-tc interval greater than 0.54 ms. or repetitive ventricular arrythmias (6).

The accepted hypothesis for the pathogenesis of this condition is felt to be due to sympathetic imbalance between cardiac sympathetic nerves of the right and left side of the heart (7). This has been mimicked in dogs where right-sided stellectomy decreased ventricular fibrillation and left-sided stellectomy increased the ventricular fibrillation threshold giving a protective effect (8).

Present management has focused on beta blockers with a high degree of success in most symptomatic patients. The main goal of therapy has been to prevent recurrence of torsades de pointes and syncope. All antiarrythmic agents as a rule are generally avoided in treating LQTS.

In patients who suffer from excessive bradycardia on beta blockers or have recurrence of syncope, left stellate ganglionectomy has produced consistent disappearance of syncopal episodes on follow-up (9). In refractory cases, permanent cardiac pacing (atrial or ventricular) combined with beta blockers has succeeded in preventing symptoms in a small subset of patients (10). Lifelong therapy has been advocated, as little data is available to show prognosis in discontinuation of therapy after patients have been rendered asymptomatic or their q-tc interval has returned to normal (less than 0.44 ms).

Summary algorithms for management of LQTS patients are presented in Figure 2 and in an article by Moss and Robinson (11).

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Sporadic multiple lipomatosis: A case report and review of the literature

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Abstract

The finding of multiple lipomas, or lipomatosis, can be a marker for several clinical or familial syndromes. Familial multiple lipomatosis is a benign hereditary disorder of adipose regulation associated with hyperlipidemia. Multiple symmetric lipomatosis involves the local infiltration of adipose tissue of the neck, upper torso and mediastinum. This condition is often found in alcoholics and has been associated with diabetes mellitus. An afflicted patient's family history is important both to reveal occult pathology and to help determine the disease's prevalence in the population. In this article, we report the case of a patient with sporadic multiple lipomatosis and provide a brief review of the literature.

Introduction

Lipomas are the most common soft tissue tumor. They comprise almost one half of benign soft tissue tumors and are usually discovered by accident since there are usually no symptoms (1). The occurrence of multiple lipomas, or lipomatosis, in a patient, however, can be a marker for several clinical or familial syndromes.

In this article, a patient with sporadic multiple lipomatosis will be presented along with a brief review of the literature.

Case report

A 49-year-old black male presented to the General Surgery Clinic at the Memorial Division of CAMC in Charleston with a history of multiple painful lipomas which he reported had been increasing in size. He first noticed the masses at age 29. Most were painless, and occurred on the trunk. Several, though, on his lower back were painful, and he had these removed surgically in 1985 without complications or evidence of malignancy.

For approximately the next five years, this patient was asymptomatic. He then began noticing firm, painful masses over his upper abdomen, lower chest and inguinal regions bilaterally. Several other masses were non-tender.

The patient said he did not know of any other members of his family having lipomas. He also denied prior local trauma, alcohol abuse, periods of rapid weight gain or loss, diabetes mellitus, or other endocrinologic disease. He was being treated for depression.

Physical exam revealed a well-developed, non-obese black male. The lipomas ranged in size from 1 cm. to 3 cm., and were located in a distribution involving the trunk, lower back and inguinal regions bilaterally. The neck, face and extremities were spared. The lipomas over the sternum, upper abdomen, and in the groin were tender to palpation.

A total of 13 masses were removed under general anesthesia. Pathologically, six specimens were lipomas and seven were found to be angiolipomas. There was no evidence of malignancy.

Discussion

Multiple lipomas occur in 1% - 7% of patients with lipomas. They most often present in the fifth and sixth decades and are more common in men than women. They often occur during periods of rapid weight gain, and are more common in obese patients (2).

Angiolipomas can occur sporadically, in conjunction with lipomas, or in families (3). These benign, painful nodules consist of mature adipose tissue and proliferating capillaries in varying proportions (4).

Two distinct, but sometimes confused, clinical syndromes of multiple lipomas have been reported -- familial multiple lipomatosis (FML) and multiple symmetric lipomatosis (MSL). FML has a strong familial component that is characterized by multiple discrete encapsulated lipomas. MSL is also believed by some to be familial (5), but this syndrome involves diffuse fatty infiltration of the neck, shoulder, and interscapular tissues.

FML is believed to be an autosomal dominant syndrome with incomplete penetrance (6). It is characterized by multiple smooth, round to ovoid non-tender subcutaneous nodules that are found on the forearms, arms, trunk and thighs. The prevalence of FML in the general population is unknown.

The masses characteristically reach a maximal size of between 0.5 cm. and 6.0 cm. after an initial period of rapid growth. The tumors rarely spontaneously regress, and in fact, their volume has been observed to persist through periods of emaciation. This is due to a deficiency in lipoprotein lipase (3). They are stated to never undergo malignant change (1), however, cases of liposarcomas have been reported in patients with a history of subcutaneous lipomas (7).

FML was first reported in 1846 by Brodie (6). Since then, the syndrome has been reported under various names including "discrete lipomatosis," "non-symmetric subcutaneous lipomatosis," and "multiple circumscribed lipomas." FML has been associated with other diseases, but its etiology is not well understood. Cases of lipomas arising from sites of prior trauma have been reported (6), and links to neurofibromatosis, diabetes mellitus and MEN syndromes have been suggested (3,6). Lipomatosis can be a feature of Gardner's Syndrome, and in 1989, Rubinstein reported a family with FML in which the affected members also had hypercholesterolemia (8).

The diagnosis of FML is clinical, but can be confirmed by excisional biopsy. Treatment of these benign tumors is primarily conservative, and indications for surgical removal are pain (angiolipomas) and for cosmesis. The recurrence rate is approximately 5% (2).

MSL was first reported in 1888 by Madelung who described an infiltrating adipose hyperplasia around the neck and shoulders of male brewery workers. This syndrome is well defined and is known alternately as "benign symmetric lipomatosis," "Madelung's disease," or "Launois-Bensaude adenolipomatosis." Associated with alcoholism, MSL occurs four times more commonly in males.

The symmetric distribution of bulky infiltrating subcutaneous adipose

tissue of the neck, interscapular region and mediastinum is a consistent feature of MSL. Peripheral and autonomic neuropathies independent of the alcoholism are also observed, and space-occupying mediastinal syndromes often coexist (5). In 40%-60% of the patients, adipose hyperplasia of the abdomen, hips, arms and thighs mimicking simple obesity is seen, and one case of malignant degeneration has been reported (9).

Approximately 200 patients have been reported with MSL. This disorder has been extensively studied as a model for adipose regulation, and is characterized as a triglyceride storage disease. Increased lipoprotein lipase activity, decreased adrenergic-stimulated lipolysis, brown adipose ultrastructural features, and mitochondrial dysfunction have been reported (5,10,11).

Treatment for MSL involves surgical resection to prevent airway compromise and mediastinal compression. Both open surgical excision and liposuction have been extensively reported (12).

For both FML and MSL, the finding of abnormal adipose distribution or multiple masses consistent with lipomas can be a marker for occult pathology. A careful family history with appropriate screening of family members should be pursued to help better define the prevalence of both FML and MSL in the population.

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1. Title page
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3. Text
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5. References in parentheses numbered consecutively. No more than 25 references will be published free of charge.
6. Tables
7. Legends for illustrations

All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the concept.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing its most commonly known trade name.

Tables (tabular listings) and figures (photos, drawings and charts) should be numbered, and the point of reference in the text indicated in parentheses, i.e. (Table 1), (Figure 10). Photos must be unmounted glossy prints in a 5 in. x 7 in. format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be done in solid black on pure white.

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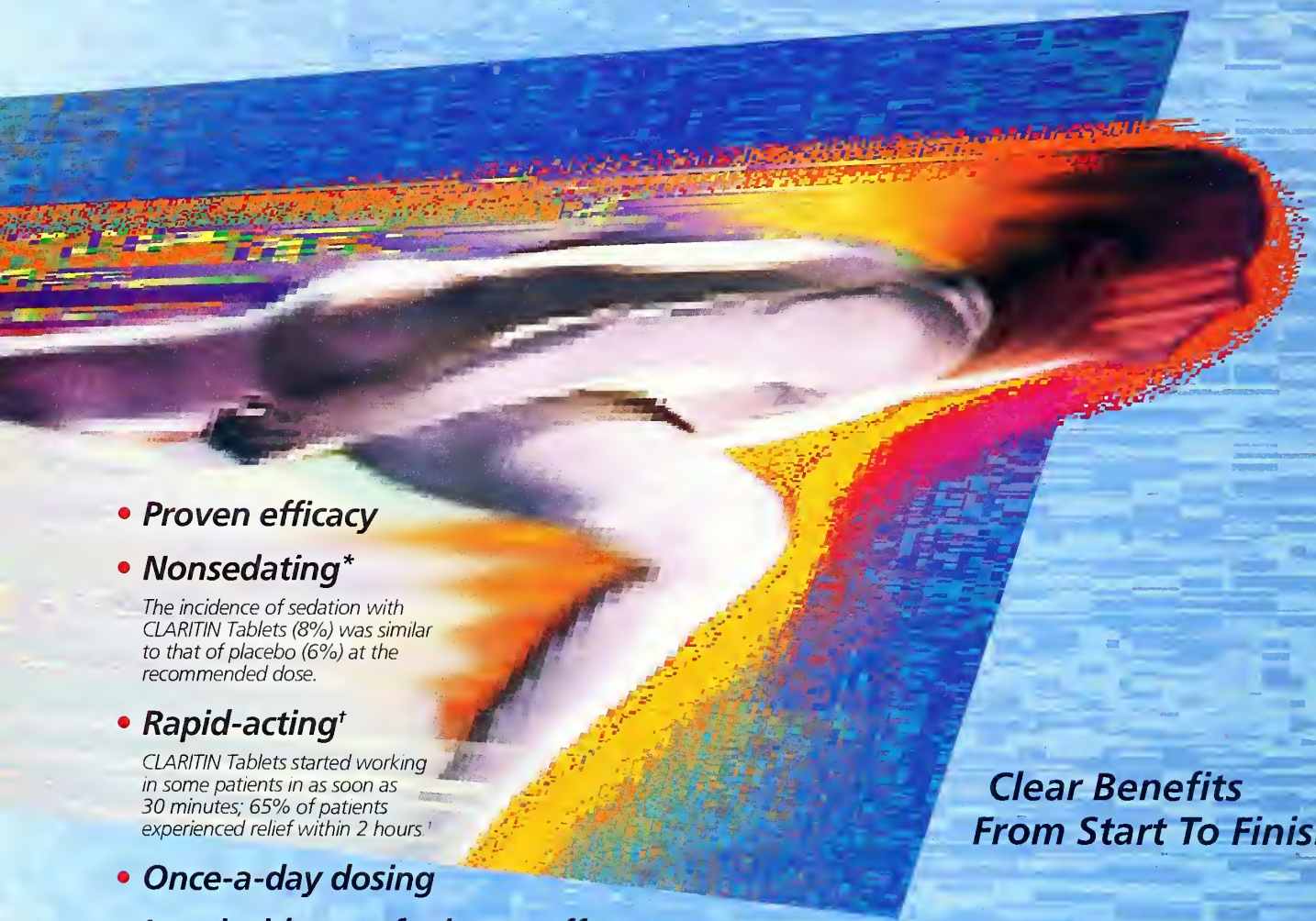

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Drug Interactions: The coadministration of a single 20 mg dose of CLARITIN Tablets (double the recommended daily dose) and a 200 mg dose of ketoconazole twice daily to 12 subjects resulted in increased plasma concentrations of loratadine (180% increase in AUC) and its active metabolite, descarboethoxyloratadine (56% increase in AUC). However, no related changes were noted in the QTc on ECGs taken at 2, 6, and 24 hours after the coadministration of loratadine and ketoconazole. Also, there were no significant differences in clinical adverse events between CLARITIN Tablet groups with or without ketoconazole.

Other drugs known to inhibit hepatic metabolism should be coadministered with caution until definitive interaction studies can be completed. The number of subjects who concomitantly received macrolide antibiotics, cimetidine, ranitidine, or theophylline along with CLARITIN Tablets in controlled clinical trials is too small to rule out possible drug-drug interactions. There does not appear to be an increase in adverse events in subjects who received oral contraceptives and CLARITIN Tablets compared to placebo.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: In an 18-month oncogenicity study in mice and a 2-year study in rats, loratadine was administered in the diet at doses up to 40 mg/kg (mice) and 25 mg/kg (rats). In the carcinogenicity studies, pharmacokinetic assessments were carried out to determine animal exposure to the drug. AUC data demonstrated that the exposure of mice given 40 mg/kg of loratadine was 3.6 (loratadine) and 18 (active metabolite) times higher than a human given 10 mg/day. Exposure of rats given 25 mg/kg of loratadine was 28 (loratadine) and 67 (active metabolite) times higher than a human given 10 mg/day. Male mice given 40 mg/kg had a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) than concurrent controls. In rats, a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) was observed in males given 10 mg/kg and males and females given 25 mg/kg. The clinical significance of these findings during long-term use of CLARITIN Tablets is not known.

In mutagenicity studies, there was no evidence of mutagenic potential in reverse (AMES) or forward point mutation (CHO-HGPRT) assays, or in the assay for DNA damage (Rat Primary Hepatocyte Unscheduled DNA Assay) or in two assays for chromosomal aberrations (Human Peripheral Blood Lymphocyte Clastogenesis Assay and the Mouse Bone Marrow Erythrocyte Micronucleus Assay). In the Mouse Lymphoma Assay, a positive finding occurred in the nonactivated but not the activated phase of the study.

Loratadine administration produced hepatic microsomal enzyme induction in the mouse at 40 mg/kg and rat at 25 mg/kg, but not at lower doses.

Decreased fertility in male rats, shown by lower female conception rates, occurred at approximately 64 mg/kg and was reversible with cessation of dosing. Loratadine had no effect on male or female fertility or reproduction in the rat at doses of approximately 24 mg/kg.

Pregnancy Category B: There was no evidence of animal teratogenicity in studies performed in rats and rabbits. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, CLARITIN Tablets should be used during pregnancy only if clearly needed.

Nursing Mothers: Loratadine and its metabolite, descarboethoxyloratadine, pass easily into breast milk and achieve concentrations that are equivalent to plasma levels with an AUC_{milk}/AUC_{plasma} ratio of 1.17 and 0.85 for the parent and active metabolite, respectively. Following a single oral dose of 40 mg, a small amount of loratadine and metabolite was excreted into the breast milk (approximately 0.03% of 40 mg over 48 hours). A decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. Caution should be exercised when CLARITIN Tablets are administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children below the age of 12 years have not been established.

ADVERSE REACTIONS
Approximately 90,000 patients received CLARITIN Tablets 10 mg once daily in controlled and uncontrolled studies. Placebo-controlled clinical trials at the recommended dose of 10 mg once a day varied from 2 weeks' to 6 months' duration. The rate of premature withdrawal from these trials was approximately 2% in both the treated and placebo groups.

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PERCENT OF PATIENTS REPORTING

	LORATADINE 10 mg QD n = 1926	PLACEBO n = 2545	CLEMASTINE 1 mg BID n = 536	TERFENADINE 60 mg BID n = 684
Headache	12	11	8	8
Somnolence	8	6	22	9
Fatigue	4	3	10	2
Dry Mouth	3	2	4	3

Adverse event rates did not appear to differ significantly based on age, sex, or race, although the number of non-white subjects was relatively small.

In addition to those adverse events reported above, the following adverse events have been reported in 2% or fewer patients:

Autonomic Nervous System: Altered salivation, increased sweating, altered lacrimation, hypoesthesia, impotence, thirst, flushing.
Body As A Whole: Conjunctivitis, blurred vision, earache, eye pain, tinnitus, asthenia, weight gain, back pain, leg cramps, malaise, chest pain, rigors, fever, aggravated allergy, upper respiratory infection, angioneurotic edema.
Cardiovascular System: Hypotension, hypertension, palpitations, syncope, tachycardia.
Central and Peripheral Nervous System: Hyperkinesia, blepharospasm, paresthesia, dizziness, migraine, tremor, vertigo, dysphonia.
Gastrointestinal System: Abdominal distress, nausea, vomiting, flatulence, gastritis, constipation, diarrhea, altered taste, increased appetite, anorexia, dyspepsia, stomatitis, toothache.
Musculoskeletal System: Arthralgia, myalgia.
Psychatric: Anxiety, depression, agitation, insomnia, paronria, amnesia, impaired concentration, confusion, decreased libido, nervousness.
Reproductive System: Breast pain, menorrhagia, dysmenorrhea, vaginitis.
Respiratory System: Nasal dryness, epistaxis, pharyngitis, dyspnea, nasal congestion, coughing, rhinitis, hemoptysis, sinusitis, sneezing, bronchospasm, bronchitis, laryngitis.
Skin and Appendages: Dermatitis, dry hair, dry skin, urticaria, rash, pruritus, photosensitivity reaction, purpura.
Urinary System: Urinary discoloration, altered micturition.

In addition, the following spontaneous adverse events have been reported rarely during the marketing of loratadine: peripheral edema, abnormal hepatic function, including jaundice, hepatitis, and hepatic necrosis, alopecia, seizures, breast enlargement, erythema multiforme, and anaphylaxis.

OVERDOSAGE
Somnolence, tachycardia, and headache have been reported with overdoses greater than 10 mg (40 to 180 mg). In the event of overdosage, general symptomatic and supportive measures should be instituted promptly and maintained for as long as necessary.

Treatment of overdosage would reasonably consist of emesis (ipecac syrup), except in patients with impaired consciousness, followed by the administration of activated charcoal to absorb any remaining drug. If vomiting is unsuccessful, or contraindicated, gastric lavage should be performed with normal saline. Saline cathartics may also be of value for rapid dilution of bowel contents. Loratadine is not eliminated by hemodialysis. It is not known if loratadine is eliminated by peritoneal dialysis.

Oral LD_{50} values for loratadine were greater than 5000 mg/kg in rats and mice. Doses as high as 10 times the recommended clinical doses showed no effects in rats, mice, and monkeys.

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The Bottom Line

What is your bottom line?

Have you been asked that question yet? I have been searching for a good definition and thought I might share my work with you. First, I had to decide from which discipline this term originated. Was it coined first by an accounting firm or in some backroom union negotiations? "O.K. boys, just give me your bottom line." Or maybe a patient coined it. "O.K. doc, I know I'm sick but just give me the bottom line."

Regardless of where it was first used, the bottom line is a phrase which has been showing up recently in many conversations and generally it is used in these four ways:

1. The difference between income and expenses.
2. The final number in a financial deal after much pencil sharpening.
3. The final result after studying a complex situation.
4. The limit to which one is willing to compromise.

The fourth use has been the way this term has been showing up in many medical conversations lately. I don't mean in discussions about patient care (which we seem to have less of recently), but in conversations with insurance companies who will now be competing for your participation. We may find physicians in heavy competition for participation in some insurance plans that will try to limit the panel of physicians offered as a method to control cost.

Unfortunately, physicians are not very good pencil sharpeners. We tend to spend most of our time thinking about patient care -- or try to at least. I believe that when President Clinton talks about the retraining of physicians he may also be including "Pencil Sharpening 101."

With all this talk of competition, will patient populations become commodities that will be traded to the lowest or highest bidder? It may become common to move from insurance plan to insurance plan, or from physician to physician annually (or more often), based on who gets or gives the better deal. Some of these deals may be based on things that have nothing to do with patient care, such as future rights to a network or a first-round pick in the 1998 Primary Physician Draft.

There is no doubt that you will be or have been in some of these negotiations already. We have to resist the urge to turn patients into commodities that will be bargained for, or physicians into players with agents looking for a piece of the action.

Remember that your bottom line has been and will always should be **the patient and quality of care.** Don't compromise your bottom line for cents on the dollar -- no matter how hard you may be pushed.

James L. Comerci, M.D.

Managed care

These two words have always managed to clank with doctors. What do they think we have been doing with care all these years? Care doesn't just happen. Someone has always made it happen and that someone has always been a doctor.

What the phrase managed care really implies is that someone other than a doctor should manage the care or, at best, someone other than the doctor ultimately to be responsible should be the "manager." Thus, Dr. Soandso from Chicago, Boston or Minneapolis can call you and begin dictating what care your patient's insurance plan will pay for, even though he or she has never seen, touched or talked to this patient. If you happen to be dealing with an HMO, the call will usually be from someone other than a doctor who, if you demand it, will identify themselves as a nurse. Of course, if you protest about being told about how to care for your patient, invariably this individual will say you may proceed as you wish, but that the insurance company will not be paying for it.

Seemingly overlooked is the fact that not everything we do is of an emergency nature. Since Hippocrates, most of the things doctors have been called upon to do for patients have been interventions or procedures to relieve discomfort, partially disabling pain or other self-limited conditions. Under "managed care," all of these tend to be looked at with a jaundiced eye and discouraged in a variety of ways.

In case it escapes your attention, what is being questioned is not just your judgement, but your integrity as well. That insurance company and that HMO do not consider you honest enough to make decisions for your patient. It's a shame and a disgrace that we have allowed this to happen without some protest. If there is a fault to be named, it is that we have allowed, without loud protest, concern for the integrity of an insurance company's financial balance sheet to override concern for the integrity of the physical and mental wellbeing of our patients.

That wellbeing is the core of concern of the doctor/patient relationship touted since the days of Hippocrates. Non-physicians have no such concern. It is no real criticism of an insurance company, or of any profit-making commercial establishment for that matter, to state that it has no such concern. The responsibility of profit-making enterprises generally stops at a focused concern for their balance sheet. They are supposed to make money. Any other area of concern or responsibility comes in a distant second. This same level of responsibility applies to any of their employees, including those irritating people making those phone calls.

Since there is no basis in ethical principles and only the pragmatic concern for making money, certain problems arise in managing care for HMOs and insurance companies, and in obtaining care for the patients they cover. Raises and promotions for employees are generally based on how well any given employee advances the company's goals. Because of this fact, it is not unreasonable to expect that employees will act in their own self interest, at least at times and some more often than others.

This problem is particularly bad for employees of self-funded companies and those insurance companies that contract out the job of managing care. Such contracts are based on the contractor's capability of, or guarantee of, reducing expected medical care costs. For anyone at all familiar with medical care, it takes little imagination to conceive how, in the absence of ethical, moral and legal constraints, one might reduce any medical cost figure by any suggested percentage or dollar amount. Herein lies the danger.

Those in the business of "managed care" care about dollars. They are motivated by the need to save and accumulate dollars. Pain, suffering, misery, in a business sense, are words lacking in any motivational quality. To physicians, these words are a call to action.

At this point, it seems that no matter how trendy and politically correct it might currently seem, doctors can do nothing more than dislike and resist "managed care." We can thank Hillary for a new appreciation of the depth and meaning of this term. It took a battalion of lawyers and 1,346 pages of legalese to explain it all, but now it seems pretty clear.

– Stephen D. Ward, M.D.
Editor

In My Opinion

My answer, or don't confuse me with the facts

In the debate over health care, it is vital that we stay informed and that we counter emotional blathering with facts. Here are my responses to the major arguments offered by the radical reformers:

1. **Argument:** AMA does not speak for most doctors. After all, only 49% of doctors belong to AMA.

   Reply: Yes, and President Clinton represents only 43% of the electorate.

2. **Argument:** Costs are "skyrocketing" and something must be done.

   Reply: According to the Bureau of Labor and Statistics, medical inflation was 5.4% in 1993 -- the lowest in 20 years. Among the six most developed countries (U.S., U.K., France, Germany, Japan and Canada), the U.S. ranked fifth out of six in medical inflation over the last 20 years.

3. **Argument:** Managed care, including HMOs will restrain the surge in medical costs.

   Reply: The Congressional Budget Office has concluded there is no evidence that managed care can save money. The Health Care Financing Administration (HCFA) has studied Medicare recipients in HMOs and concluded that patients spend 6% more for HMO care than they do with straight fee-for-service. Currently 25% of the insured population is in an HMO and many more are covered by managed care plans, yet there has been no discernable effect on overall medical costs.

4. **Argument:** We pay more for medical care than any other country.

   Reply: We have the best medical care in the world and the best always costs more. Foreigners do not come to the United States to see how we make cars, but how we practice medicine. The cheapest treatment is not always the best. Aspirin and crutches are cheaper than a hip replacement. Other countries do not have the burden of AIDS, gun-related violence, drug addiction and teenage pregnancies that we have.

5. **Argument:** There are 39 million Americans who do not have insurance.

   Reply: This figure includes individuals between jobs, those who choose not to have insurance, all those without health insurance for any part of the year, so it is much lower at certain times. All of these people still get health care despite their lack of insurance.

6. **Argument:** Universal coverage is necessary to prevent cost-shifting.

   Reply: Studies of cost-shifting have consistently shown that the cause is not the relatively few uninsured patients presenting for care, but Medicare and Medicaid failing to pay the costs associated with care.

7. **Argument:** A single-payor system would be the most efficient means of providing health care and it would lower administrative costs.

   Reply: A single-payor means the government only. Government has not earned the trust of the public with previous programs such as Medicare, Medicaid, the VA, military medicine and the U.S. Public Health Service, all of which have promised more than delivered.

8. **Argument:** Doctors are only a special interest group out to protect their own turf.

   Reply: In health care, there are no disinterested parties. The government is the payor for 42% of current health care. Do you really think they only talk to angels and have no stake in the outcome?

9. **Argument:** What about poor old Sally Hardluck, who developed breast cancer two weeks after losing her job and now needs a bone marrow transplant?

   Reply Let's get away from ancedotes. If ancedotes are persuasive, they would prove that capitalism is no good. After all, capitalism breeds bankruptcies, and I might add, success.

10. **Argument:** The main causes of soaring costs are greedy doctors, gouging drug companies and profiteering hospitals.

    Reply: The main cause of medical inflation is advances in technology and the aging of the population. Half of all hospitals had to lay off staff last year, drug companies are laying off thousands and drug inflation last year was 3.1%.

11. **Argument:** Doctors do not like old people.

    Reply: Doctors invented old people.

Wallace D. Johnson, M.D.
Beckley

Our Readers Speak

More appropriate for the editorial page

A middle school West Virginia history teacher recently asked his class, "Why is there so much poverty in West Virginia?" His answer was "because we have too many poor people." Robert M. Frumkin, Ph.D., seemed to reach the same conclusion in your February feature article, *"Employment, Race and Poverty in West Virginia: Implications for Practicing Physicians."*

After an informative article with well-researched demographics, the author concludes with an editorial expressing his opinion in favor of abortions. He states that abortions are "generally necessary" for unplanned pregnancies. His answer for reducing the number of poor African-Americans in West Virginia is to make sure they don't survive until birth. He goes further to tell us how "physicians must respond." His concluding comments should have been on the editorial page rather than part of a feature article in a scientific journal.

Hoyt J. Burdick, M.D., F.A.C.P., F.C.C.P.
Huntington

The Hospital Medical Staff Section 23rd Assembly Meeting

June 9-13, 1994 Chicago Marriott Hotel Chicago, Illinois

Interactive Dialogue with AMA Board of Trustees

HMSS representatives will not want to miss this year's AMA-HMSS Annual Assembly Meeting held on **June 9-13** in Chicago. Aside from the usual policy-related activities, representatives will have an opportunity to dialogue with the AMA Board of Trustees, hear the latest news and information from Washington, and learn the importance of and methods for physician involvement in health system reform.

The Friday education program hosts an impressive panel of speakers. From their remarks, representatives will learn: the impact of proposed legislation on the future practice of medicine; the kinds of managed care entities most likely to thrive; the ways to cope with health care delivery changes at the local level; the support needed to pass legislation on physician involvement in health system reform; the steps for developing a physician-directed health delivery network or plan; and the best methods for managing patient care and physician compensation in physician health plans.

Physician Involvement in Health System Reform

With health system reform legislation pending before Congress, state health system reform initiatives, and the rapid development of integrated delivery systems, it is vitally important that medical staffs mobilize to stand up and speak out for patients and the profession. The June Assembly meeting is no exception. Now perhaps more than ever before, HMSS representatives need to be involved in shaping the nation's future health care system.

HMSS past actions have made a difference. The AMA has incorporated many issues advocated by HMSS in its new health system reform proposal for action and model legislation. Basically, the draft bill:

- requires that health plans establish a medical staff structure with defined rights with regard to the plan's medical policy, utilization, quality and credentialing and management issues;
- expressly permits physicians to jointly present their views on any plan issue (without boycott or strikes) to plan management for discussion and negotiation;
- directly aids physicians in the creation of their own plans or networks to compete with large insurance companies;
- requires negotiation of new regulations with the profession before their announcement ; and
- expands the role and protection for the profession's accreditation, standard setting and medical society disciplinary functions.

Success will depend on unified physician support and action. Mark your calendar and plan to attend!

For more information please call 312 464-4754 or 464-4761

American Medical Association
Physicians dedicated to the health of America

At Annual Meeting

Noted vascular surgeon to deliver Harris Address

John J. Bergan, M.D., F.A.C.S., HON., F.R.C.S.(ENG.), a clinical professor of surgery at the University of California in San Diego, will present this year's Thomas L. Harris Address on Friday, August 19 during the First Session of the WVSMA House of Delegates at the WVSMA's 127th Annual Meeting at The Greenbrier in White Sulphur Springs. His topic will be "Current Management of Extracranial Cerebral Vascular Disease."

Dr. Bergan received his medical degree from the Indiana University School of Medicine in 1954, where he also completed his internship. He was influenced by the vascular surgery of Dr. Harris Shumacker during his internship and decided to complete his residency at the Northwestern University Medical School under the guidance of Dr. Walter Maddock, one of the founders of the Society for Vascular Surgery. Upon finishing his residency in 1959, Dr. Bergan was appointed to the faculty of Northwestern University.

Dr. Bergan

Early research interests in pancreatitis quickly led Dr. Bergan to explorations of vascular injury in this condition and then to the study of intestinal ischemia. This area of research continued to be Dr. Bergan's major interest, but he also began studying renal transplantation, pancreatic transplantation, and liver preservation. His activities in transplantation led to his appointments as chief of transplantation at Northwestern University Medical School in 1969 and as director of the Organ Transplant Registry at the American College of Surgeons in 1970.

Since 1973, Dr. Bergan has been devoting his time to vascular surgery exclusively, describing the selective portosystemic shunt, and developing the non-invasive laboratory at Northwestern University Medical School with Dr. Yao. His interests in innovations in presentation led to the breakfast sessions held annually at the meetings of the Society for Vascular Surgery and the International Society for Cardiovascular Surgery, North American Chapter. Dr. Bergan was also instrumental in the formation of the Midwestern Vascular Surgery Society and the American Venous Forum.

In 1989, Dr. Bergan was named to his current position as a clinical professor of surgery at the University of California at San Diego. That same year, he also assumed his other two current posts as a clinical professor of surgery at the Uniformed Services University of the Health Sciences in Washington, D.C., and as an academic consultant in vascular surgery at Balboa Naval Hospital in San Diego.

During his career, Dr. Bergan has received numerous honors, including being awarded the Rovsing Silver Medal of the Danish Surgical Society and honorary memberships in the Royal College of Surgeons in England, the Vascular Society of Great Britain and Ireland, and the Vascular Surgery Section of the Royal Australasian College of Surgeons. He is a past president of the Society for Vascular Surgery, the European-American Venous Symposium, the American Venous Forum, the International Association of Vascular Surgeons, the Chicago Surgical Society, and the Gulf Coast Vascular Society.

Dr. Bergan is a member of several editorial boards including *Surgery, Journal of Vascular Surgery, Journal of Cardiovascular Surgery, the Annals of Vascular Surgery, British Journal of Surgery, Phlebology,* and is the founder/editor of *Postgraduate Vascular Surgery* and *International Vascular Surgery*. He is the co-editor of a number of textbooks of vascular surgery, and is the former editor of the annual *Year Book of Vascular Surgery*.

Information about other speakers at this year's WVSMA Annual Meeting will be published in upcoming issues of the *Journal* and a registration form appears on page 155. For more details, contact Nancie Divvens at (304) 925-0342.

Legislative Reception

At the WVSMA's Legislative Reception at the Charleston Marriott, Delegate Karen Facemeyer discusses health care issues with Dr. Jeff Stead and Delegate Robert Pulliam, M.D., who is Council chairman for the WVSMA. Conversing to their right are Dr. Harry Shannon and Delegate Bob Ashley.

Director of Government Relations Winnie Morano speaks with Sonia Daugherty of PEIA and Delegate Bonnie Brown about pending legislation.

Delegates Bob Ashley (left) and Nancy Kessel (third from left) who is also a member of the WVSMA Alliance, were pleased to visit with Pacita Salon, past president of the WVSMA Alliance; Judy Bofill, vice president of the WVSMA Alliance; Dr. Miraflor Khorshad; and Dr. Rano Bofill.

Charleston lawyer Jon Amores (right), a candidate for the House of Delegates, talks about his campaign with his mother, Dr. Diana Amores, Dr. Raymond Rushden, and Troy Hendricks, a former member of the House of Delegates.

Members of the Office Managers Association, Gary Linkous of Princeton Orthopedic Center; Carol Simpson of the office of Dr. Kenneth Clark; Teresa Painter of Infectious Disease Consultants; Dianna Yerrid of Medical Imaging Services, Inc.; and Sue Simpson of the office of Drs. Pearcy, Busch and Hill; take a break from mingling to enjoy the buffet. The members of the Office Managers Association are very important in helping the WVSMA in its legislative efforts.

WVSMA to sponsor CME workshop with CAMC, MU, WVU

At the request of many accredited health care providers of CME, the West Virginia State Medical Association's Committee for Medical Education, in conjunction with the Charleston Area Medical Center, Marshall University and West Virginia University, is conducting a one-day workshop entitled "*CME: Paradigms of the Future.*"

Set for Thursday, May 19 at the Robert C. Byrd Health Sciences Center of WVU, Charleston Division, this workshop is designed for directors of medical education, medical education coordinators and all others involved in the planning, development, implementation and evaluation of CME activities. It will also prepare individuals interested in obtaining accreditation for sponsorship of CME activities.

After a welcome at 9:30 a.m. by Dr. John W. Traubert, chairman of the WVSMA's Committee for Medical Education, and WVSMA President Dr. James L. Comerci, the workshop will begin with a presentation on "*The History and Future of CME,*" by Frances Maitland, executive director of the Alliance for Continuing Medical Education. The Alliance is an international professional association with over 1,400 members, concerned exclusively with continuing medical education.

Ms. Maitland was formerly the assistant secretary of the Accreditation Council for Continuing Medical Education. She served in this capacity since the inception of the ACCME on January 1, 1981, and as assistant secretary of the former Liaison Committee on Continuing Medical Education since 1978. A graduate of the University of Michigan, Ms. Maitland has also held positions with the Council of Medical Specialty Societies and the American Academy of Orthopaedic Surgeons.

Following Ms. Maitland's lecture, Michael I. Gannon, associate director of CME for the AMA, will discuss "*Category 1 and 2 - Differences and Reporting Mechanisms.*" Mr. Gannon has been involved in CME at the AMA for the past 15 years.

After a break, the workshop will continue with a lecture by David F. Lichtenauer, B.S., M.A., a CME consultant from Cincinnati. Mr. Lichtenauer will discuss "*How FDA Policy Affects CME Resources.*"

An employee of the Upjohn Company for the past 30 years, Mr. Lichtenaur served as Upjohn's liaison with many of the national associations in medical education as part of the Medical Sciences Liaison/Education Unit. Since October 1, 1992, he has been the medical relations manager of national medical organizations for Upjohn.

Mr. Lichtenauer is a member of the Alliance for Continuing Medical Education's (ACME) Board of Directors and serves on the Industry/CME Collaboration Task Force that produced the revised ACCME Standards for Commercial Support of CME. In September 1993, the ACME appointed him to their External Monitoring Committee, which evaluates, suggests, implements and addresses complaint procedures relative to the random monitoring procedures for ACME at national and state levels.

Following Mr. Lichtenauer's lecture, a luncheon will take place at noon. The speaker for this luncheon will be WVSMA Executive Director George Rider, who will discuss "*The Medical Practice Act.*" The afternoon sessions will then be devoted to topics dealing with the accreditation process and program approval in West Virginia. The format will be an informal one with active audience participation.

The first afternoon session will feature a demonstration of MDTV/ Medline, which will be conducted by Dr. James Brick and Dr. Joseph Skaggs. Next, Dr. John Traubert and WVSMA Associate Executive Director Nancie Divvens will discuss the factors needed for obtaining CME accreditation.

The sessions will continue with a panel on "*Approving Programs - Essentials and Standards*" with Frances Maitland, David Bailey of MU's CME Program, Robin Rector, director of continuing education and conference services for CAMC, and Kari Long, program director of CME and rural services for the Robert C. Byrd Health Sciences Center, Morgantown. The last session will focus on "*What the Surveyor Looks For,*" with Dr. Traubert, WVSMA Vice President Dr. James Helsley, and Dr. Comerci. The meeting will conclude with a question and answer session with all of the day's speakers.

The registration form is printed below and you may contact Nancie Divvens at (304) 925-0342 for more details.

Registration Form

Name _____

Title _____

Organization _____

Phone _____

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City _____ State ____ Zip Code _____

Registration fee: $125

Physician members: $75

Payment by: ___Check ___Visa ___MasterCard

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If paying by check, please send registration form and check to:

West Virginia State Medical Association
P.O. Box 4106
Charleston, WV 25364
(304) 925-0342

The West Virginia State Medical Association's

1994 Annual Meeting

August 17-20, 1994

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White Sulphur Springs, West Virginia

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Space is being held at other area hotels/motels, contact the WVSMA at 304-925-0342 for more details. For your convenience, you may call the WVSMA office and register for the conference using your Visa or Master Card.

1994 Annual Meeting

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Conference Cost:	WVSMA member	$125 ___
	non-member	$175 ___
Additional:		
Thursday, Aug. 18		
Learn and Learn (CME Credit)	member/non-member	$ 40 ___
	spouse/student	$ 25 ___
Friday, Aug. 19		
Lunch and Learn (CME Credit)	member/non-member	$ 40 ___
	spouse/student	$ 25 ___
	TOTAL:	___

If paying by check, please send registration form and check to:
West Virginia State Medical Association
P.O. Box 4106, Charleston, WV 25364

Continuing Medical Education

Listed on this page are some of the upcoming CME programs which will be held in the state. Unless otherwise noted, the events are presented at the location under which they appear.

If you would like to have the CME programs offered by your institution or association for physicians printed in the *Journal* or obtain more details about the meetings listed, please contact Nancy Hill, managing editor, at 925-0342.

Robert C. Byrd Health Sciences Center of WVU - Charleston

April 21
(Teleconference) "Childbirth Education Update," Paula Vasale, R.N.C., B.S.N., C.E.S.

May 5
(Teleconference) "Respiratory Distress in the Newborn," Stefan R. Maxwell, M.D.

May 11-12
(Seminar) "3rd Annual Issues in Perinatal Health Care"

May 17
(Seminar) "Management of a Congenital Neck Mass" (sponsored by The Eye and Ear Clinic of Charleston and the Dept. of Surgery), R. Austin Wallace, M.D., F.A.C.S.

May 19
(Teleconference) "Blood Borne Pathogens: The Health Care Providers' Risk," Elizabeth A. Funk, M.D.

June 2
(Seminar) "ABC's of Caring for HIV-Infected Patients," Elizabeth A. Funk, M.D.

June 16
(Seminar) "Pediatric Update," Naser Tolaymat, M.D.

June 21
(Seminar) "Management of Salivary Gland Disorders," (sponsored by The Eye and Ear Clinic of Charleston and the Dept. of Surgery), Robert E. Pollard, M.D.

Robert C. Byrd Health Sciences Center of WVU - Morgantown

April 22-24
"West Virginia State Radiological Society Spring Meeting: Breast Care Update 1994 (sponsored by the WVU Dept. of Radiology and the West Virginia State Radiological Society), Lakeview Resort and Conference Center, Morgantown

April 30
"Current Concepts in Cancer Care for the Non-Oncologist" (co-sponsored with Monongalia General Hospital), Lakeview Resort and Conference Center, Morgantown

May 1-4
"Wellness Conference," Lakeview Resort and Conference Center, Morgantown

May 20
"Second Annual Stephen C. Rector Visiting Lectureship in Emergency Medicine" (sponsored by the WVU Dept. of Emergency Medicine)

May 20-21
"5th Annual Ophthalmology Alumni Weekend" (sponsored by the WVU Dept. of Ophthalmology)

May 27-29
"Anesthesia Update" (sponsored by the WVU Dept. of Anesthesiology and the West Virginia and Virginia State Societies of Anesthesiology), The Greenbrier, White Sulphur Springs

June 2-3
"The Spiritual Dimension of Illness, Suffering and Dying (sponsored by the WVU Center for Health Ethics and Law)

West Virginia State Medical Association - Charleston

May 19

"CME Workshop: Paradigms of the Future," Robert C. Byrd Health Sciences Center of WVU, Charleston

Outreach Programs

Key to Sponsors

★ *Robert C. Byrd Health Sciences Center of WVU, Morgantown*

☐ *CAMC/Robert C. Byrd Health Sciences Center of WVU, Charleston*

Gassaway ☐ Braxton County Memorial Hospital, April 27, 6:30 p.m., "Indications and Risks of Blood Transfusions," Mary S. Taylor, M.D.

Oak Hill ☐ Plateau Medical Center, April 26, 6:30 p.m., "Pediatric Trauma," A. Margarita Torres, M.D.

Parkersburg ★ Camden-Clark Memorial Hospital, April 21, 7 a.m., TBA, N. Andrew Vaughan, M.D.

Point Pleasant ☐ Pleasant Valley Hospital, April 28, noon, "New Technologies in High Risk Obstetrics," Norman Duerbeck, M.D.

Williamson ☐ Williamson Appalachian Regional Hospital, April 28, 5:30 p.m., "Evaluation of Arthritic Patients," Michael Istfan, M.D.

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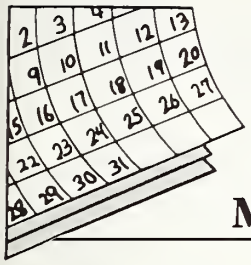


Medical Meetings

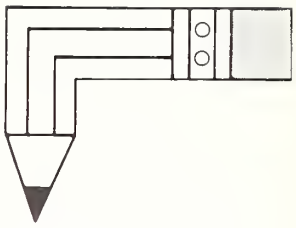
May

1-7–American Society of Neuroradiology, Nashville, Tenn.
2-5–American Pediatric Society, Seattle
7-8–American Laryngological, Rhinological and Otological Society, Palm Beach, Fla.
8-11–American College of Mohs Micrographic Surgery and Cutaneous Oncology, San Diego
8-13–American Society of Colon and Rectal Surgeons, Orlando, Fla.
9-12–American College of Obstetricians and Gynecologists, Orlando, Fla.
11-14–15th Annual Meeting of the North American Society of Pacing and Electrophysiology, Nashville, Tenn.
11-15–American Society for Dermatologic Surgery, San Diego
12-13–Building Blocks of Health Care Reform: Health Information and Quality Assessment (sponsored by AMPRA, Consumer Coalition, NAHDO and NBCH), Washington, D.C.
12-17–American Trauma Society, McLean, Va.
13-14–Topics in Radiology (sponsored by the University of Pittsburgh School of Medicine), Pittsburgh
13-15–Rheumatology and Allergy Update: 1994 (sponsored by Ohio State University), Mt. Sterling, Ohio
13-15–The Managed Care Revolution: Winning Strategies for Internists (sponsored by the American Society of Internal Medicine), Boston
14-16–4th Annual Meeting of the American College of Radiation Oncology, Washington, D.C.
14-19–American Urological Association, San Francisco
15-18–American Gastroenterological Association, New Orleans
18-20–47th Annual National Conference of the President's Committee on Employment of People With Disabilities, Atlanta
20-21–Neurology for the Non-Neurologists (sponsored by Ohio State University), Columbus
21–Fifth Annual Rush Symposium on Transplantation, Chicago
21-25–American Psychiatric Association, Philadelphia
25-28–National Rural Health Association's 17th Annual National Conference, San Francisco

For More Information . . .

Contact the Journal at (304) 925-0342.

Poetry Corner



Beauty

Beauty is in the eye of the beholder,
A person who was very wise once said,
But beauty comes in sound as well as sight,
So beauty also is in the ear of those who hear:
The sight of a bluebird in graceful flight
Against a backdrop of sun-filled summer sky;
The sound of its song carried on a gentle breeze;
The beauty of the ever-changing trees
As seen on autumn days with multi-colored
Leaves of yellow, orange, red and gold;
Seeing newly fallen snow on winter days so cold;
Budding trees in spring, and flowers' early bloom,
Dispelling certain feelings which one has
Because of winter days so drab; so full of gloom.
Music played by symphonies or sung by lovely voice;
Or choir singing choral works may be your choice.
Beauty, then, is where and how one may perceive,
And comes free of cost to those who will receive.

E. Leon Linger, M.D.

Sweetness

Her day rose was much sweet
Her sweetness was most love
Her loveliness was all white
Her whiteness was like a dove.

Romeo Y. Lim, M.D.

Please address your submissions for Poetry Corner to Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

Bureau of Public Health News

This page of material is submitted and paid for by the Bureau of Public Health.

Bureau recruiting professionals for early intervention program

The Bureau of Public Health is expanding its family-centered, interdisciplinary services for infants and toddlers with developmental delays or medical conditions that put them at risk for such delays. These children, from birth through age 2, and their families are eligible for free, federally-mandated Early Intervention Services through the Bureau's Office of Maternal and Child Health (OMCH).

Due to the state's shortage of physical therapists, occupational therapists, speech therapists and other professionals trained to work with special needs children, the Bureau's Office of Community and Rural Health Services is working with the OMCH and the Marshall University School of Medicine to develop a new recruitment program to encourage individuals to enter these fields. This new effort, the Recruitment for Early Intervention Project (REIP), will operate on three levels.

The first two levels will only be offered to West Virginia residents in order to recruit individuals who are most likely to remain in the state. Both the loan repayment program and the scholarship program will require the students to fulfill an employment contract at a community-based agency that offers early intervention services through the OMCH upon completion of their training. The third category will consist of salary supplements or incentives to recruit people already in these specialties to join West Virginia's Early Intervention Program.

Another aspect of the project will be to work with West Virginia colleges and universities to develop or expand existing training programs. Currently, the number of physical therapy and speech therapy programs available is limited, and there are no occupational therapy programs offered in the state.

Staff are now working with students and clinicians around the state to communicate the needs of the Early Intervention Program and the opportunities available. Recruiting is scheduled to begin this fall.

For more details, call Brian Loshbough at (304) 558-4007.

Study investigating Lyme Disease cases

State and federal public health officials have began an investigation into the unusually high number of Lyme disease cases reported over the past two years in Greenbrier and Raleigh counties. Staff from the Bureau of Public Health and the U.S. Centers for Disease Control and Prevention (CDC) are teaming up to conduct a health study of 52 state residents who, according to physician reports, were either diagnosed with or suspected of having Lyme disease in 1992 or 1993.

"West Virginia hasn't been considered a high incidence region for Lyme disease, and we haven't had more than 50 cases reported statewide in any given year," explained State Health Commissioner William T. Wallace Jr., M.D., M.P.H. "When it came to our attention last summer that such a large number of cases were being diagnosed in one particular part of the state, we began the process that's led to this study. We want to determine if a health problem does exist, and if so, what to do about it."

Public health workers began contacting the 52 patients in March, and those who agree to take part in the study will be interviewed to learn more about when their symptoms were first noticed, what sort of medical examinations and testing they have undergone, and what medications have been prescribed for them. Blood samples will be taken from them for further testing, and each participant will also be asked to have a household member or a neighborhood friend serve in a control group. These individuals will be near the same age as the patient, but will not have been diagnosed with the disease. Studying both the patients and the control group may help indentify how people are contracting the disease, which is often difficult to diagnose because blood tests can't always correctly identify it.

Results of the study are expected later this spring and more information can be obtained by phoning Loretta Haddy at (304) 558-5358.

Mammography sites prepare for new regs

Staff from the Bureau's Office of Health Facility Licensure and Certification (OHFLAC) and the Office of Environmental Health Services (OEHS) have been working with personnel at mammography sites around the state to ensure compliance with current and upcoming federal regulations established in the Medicare Screening Mammography Certification program.

A total of 66 hospital-based and free-standing mammography service suppliers are enrolled in the program, which grants certification by the HCFA for Medicare-funded procedures. By October 1, each facility will undergo at least one on-site inspection by OHFLAC and OEHS staff.

In October 1994, regulations implementing the Mammography Quality Standards Act of 1992 (MSQA) become effective. Unlike the current HCFA program, these regulations will apply to all mammography facilities, whether their services are screening or diagnostic, and responsibility for compliance will not be limited to facilities participating in Medicare. In order to meet the provisions of MSQA, facilities must meet federal quality standards and certification standards, and either be accredited by, or apply for accreditation by an approved accredited body.

Also, MSQA will be administered by the FDA, rather than by HCFA. Once the new program is in place, there may be no further need for HCFA to conduct the inspections that are presently occurring, depending on the manner in which FDA elects to administer the program.

For more information, contact the OHFLAC at (304) 558-0050 or the OEHS at (304) 558-2981.

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ROBERT C. BYRD HEALTH SCIENCES CENTER OF WEST VIRGINIA UNIVERSITY

Compiled from material furnished by the Robert C. Byrd Health Sciences Center of West Virginia University, Communications Division, Morgantown

Grads choose family practice, primary care

More than 60 percent of this year's graduating class from the School of Medicine have been accepted into residency programs in primary care. Nearly half the class will train as family physicians or in general internal medicine, and nearly 56 percent will stay in the state for residency training.

"This is the highest number of students choosing primary care residencies in the history of the four-year medical school," said Dr. John Traubert, associate dean for student and curricular affairs. "Of the 77 students in the Class of '94, 18 (24%) will enter family medicine residencies and an equal number will enter residency programs in general internal medicine. A total of 47 class members will be in primary care programs, including pediatrics, medicine/pediatrics and obstetrics/gynecology," he added.

"Our students have heard and understood the debate on the future of health care," said Dr. Robert D'Alessandri, vice president for health sciences and dean of the School of Medicine. "It's clear that, to meet the needs of people in the next few decades, we will have to train more, and better, primary care physicians. Many members of the Class of '94 are going to be among them.

"We will also continue to need surgeons, radiologists, anesthesiologists and other specialists and I'm certain that this class will also produce some outstanding physicians in these fields."

Applications for Med School at all time high

A record number of 1,917 students have applied to the School of Medicine for the year beginning this fall.

Of these applicants, 245 are West Virginia residents, and about 90 percent of this entering class will be selected from among these individuals.

Ducatman receives authorship award

Ducatman

Dr. Alan Ducatman, professor and director of the Institute of Occupational and Environmental Health, has been selected as this year's recipient of the Adolph G. Kammer Merit in Authorship Award by the American College of Occupational and Environmental Medicine (ACOEM).

ACOEM is presenting this award to Dr. Ducatman in recognition of his article "*The Occupational Physician and Environmental Medicine*," which was published in the March issue of the *Journal of Occupational Medicine*.

Dr. Ducatman will receive the award at the annual business meeting of the ACOEM on April 21 in Chicago.

MDTV, MARS create awareness program

Mountaineer Doctor Television (MDTV) and the Medical Access & Referral System (MARS) have started a program to increase awareness of the benefits of MDTV's audio and video communications link between rural hospitals and the HSC.

When WVU physicians receive referrals from MARS, they will be told when the physician or health care provider making the call is at an MDTV site. This will serve as a reminder to WVU physicians that they can take the process one step further and actually see the patient being discussed by the doctor. The WVU physician and the referring physician can then have a video consultation or schedule a time convenient for all parties through the MARS office.

In addition to the campus sites in Morgantown and Charleston, MDTV has sites at Wetzel County Hospital, New Martinsville; Grant Memorial Hospital, Petersburg; Davis Memorial Hospital, Elkins; St. Joseph's Hospital, Buckhannon; and Boone Memorial Hospital, Madison.

Prostate Health Center established

WVU has established the state's first Prostate Health Center to promote and coordinate education and information on prostate diseases for the public and for health care professionals.

Dr. Unyime Nseyo, associate professor of urology, is the center's director, and Dr. Stanley Kandzari, vice-chair of the Department of Urology, will be co-director. The center is funded by a grant from the Human Health Division of Merck Pharmaceuticals in Dublin, Ohio.

For more details, call the Prostate Health Center at (304) 293-1429.

Two professors elected to national posts

Mary Davis, Ph.D., and Robert Stizel, Ph.D., both professors in the Department of Pharmacology and Toxicology, have been elected to national offices.

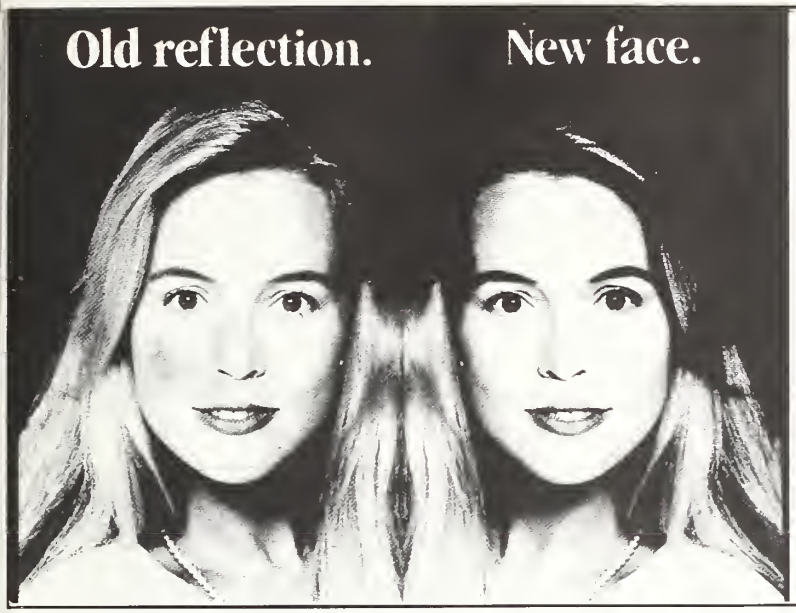
Dr. Davis will begin a three-year term as treasurer of the Society of Toxicology in May. In addition to attending to the society's budget matters, Dr. Davis will be a trustee for the Toxicology Education Foundation.

Dr. Stitzel, who is also special assistant to the provost, is in the first year of a three-year term as secretary/treasurer of the American Society for Pharmacology and Experimental Therapeutics.

Two Birthscore posters accepted for meeting

Two posters showing results from the West Virginia Statewide Birthscore System have been accepted by the International Society on Infant Studies for its conference in Paris, June 2-5.

The posters were submitted by Dr. Chet Johnson, associate professor of pediatrics and director of the W.G. Klingberg Child Development Center; RN Lois Morgan, project manager of the West Virginia Statewide Birthscore Project; and Chris Britton, Birthscore technician.



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Marshall University School of Medicine

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington.

MU expands RuralNet through worldwide Internet program

Marshall has developed a powerful computer resource that saves users worldwide from having to explore every inch of the "information superhighway" when they want material on rural health.

Six years ago, Marshall created RuralNet to give medical students the informational resources they need during their nine-month rural placements. With the advent of the statewide Kellogg and Rural Health Initiative programs, Marshall expanded the network to serve all health professions students at more than 130 sites. In March, Marshall made the resource available worldwide through Internet, a global aggregate of computer networks which links more than 11,000 subnetworks and more than 20 million users.

Once students or Internet users link into RuralNet, a simple menu system whisks them to exhaustive data collections in the blink of a cursor. Marshall computer experts extensively searched the Internet for collections relevant to rural health, then used a search and retrieve utility known as "Gopher" to automate the complex routing commands necessary to reach those collections.

The RuralNet Gopher groups resources into categories ranging from clinical resources to health science libraries to health care policy, reform and management. From there, users can reach hundreds of informational sources such as the Rural Information Center Health Service at the federal Office of Rural Health Policy and the CancerNet PDQ system of the National Cancer Institute.

Ironically, those technological capabilities so far have caused less of a stir than the infrastructure Marshall first developed to, as one staff member put it, "pave the information dirt path." Medical educators around the nation are requesting information about Marshall's system which allows students at remote sites to do Medline searches, check for drug interactions, send messages, and tap into worldwide information sources.

"We've concentrated so hard on getting these resources into the hands of students and rural communities that we only recently realized that other schools are not nearly this far advanced in rural access," said Jan I. Fox, chair of the Department of Academic Computing.

Indeed, just four days after computer educator Michael McCarthy first mentioned the program on the Internet, an official of the American Public Health Association was asking whether Marshall would demonstrate RuralNet at this fall's APHA meeting. Other institutions requesting information include the University of North Carolina, Southern Illinois University, Tulane, Yale and Harvard.

Internet users can connect to RuralNet by gophering to ruralnet.mu.wvnet.edu on port 70.

Alumnus featured in *Wall Street Journal*

Dr. John Hahn, a Marshall alumnus, recently made national headlines in a front-page *Wall Street Journal* story, *"Washington Debates Health Care for All; Dr. Hahn Delivers,"* which profiles his obstetrics practice in rural West Virginia.

The rural area Dr. Hahn serves is located, reporter Alecia Swasy wrote, "about 180 miles -- and degrees -- from Washington." Based at Grant Memorial Hospital in Petersburg, Dr. Hahn cares for mothers and infants from five rural counties. Part of that care is provided through three regional clinics he established with his brother, Jerry, a fellow MU alumnus specializing in family practice and dermatology.

The brothers grew up in the town of Wardensville and drew inspiration from the local physician, J.D. Mathias, John Hahn told the *Wall Street Journal*. He added that his desire to return to the area played a significant role in his choice of specialty: with obstetrics, he could almost assuredly get a nearby assignment in fulfilling his obligation to the National Health Service Corps.

Dr. Hahn is not new to the national spotlight; the ABC newsmagazine *"20/20"* featured him in a segment in the late 1980s.

Mufson receives Laureate Award

Dr. Maurice A. Mufson has received the Laureate Award from the West Virginia Chapter of the American College of Physicians.

This award, according to the ACP, "honors those Fellows of the American College of Physicians who have demonstrated by their example and conduct an abiding commitment to excellence in medical care, education, or research, and in service to their community, their Chapter, and the American College of Physicians."

Elected to Fellowship in the American College of Physicians in 1973, Dr. Mufson has been very active on the chapter level. He has served as chairman of the Associates' Program Committee for the last four years and is considered largely responsible for its success. The award recognizes Dr. Mufson's contributions to developing the Associates' Program, as well as his achievements in teaching and research.

Two Stanford professors to address graduating seniors

Two native West Virginian physicians who have earned international reputations in their fields will present the ceremonial Last Lecture and the Investiture address to graduating seniors.

Dr. Mary Lake Polan, chair of Obstetrics and Gynecology at Stanford University, will present the Last Lecture at 8 p.m. on Thursday, May 5, at the Huntington Museum of Art. The Wayne County native will speak on *"The Future of Women's Health."*

Logan native Dr. Joseph McGuire, professor of dermatology and pediatrics at Stanford, will address seniors at the Investiture ceremony on May 6 at Marshall's Fine and Performing Arts Center.

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Alliance News

AMPAC Campaign School a valuable experience!

I was warned! Dr. Robert Pulliam had told me the AMPAC Campaign Management School was an intense and exhausting experience, but since he is one of my husband's partners, I figured he was kidding me or exaggerating. But - - he wasn't!!!

Never before had I learned so much in such a short time. The school lasted one week and our days were filled with outstanding lectures on these five main topics:

1. Campaign Groundwork - Strategy, Planning, Theme and Management

2. Research - Targeting, Polling, Opposition and Candidate Research

3. Fundraising and Budgeting

4. Communicating Messages - Advertising, Earned Media Coverage and Field Operations

5. Scheduling and Management Decision Making

A total of 32 adults, ranging in age from about 27 years old to 60 years old, attended the school. Several were physicians, but the majority were the spouses of physicians. We were divided into four groups and after our lectures were over at 5 p.m., we had to work on our own campaigns. First, we had to determine who would be our candidate, and then we proceeded with selecting our manager and developing campaign strategy.

Our planning sessions would last long into the night. Even though I would usually say goodnight at about 1 a.m., other members of my group would continue working until about 3 a.m. Campaign school was a big game, but everyone was very competitive and took it seriously.

The quality of the people attending this school was outstanding. Many had very strong personalities, but we all possessed fine social skills which made it easy to interact. Most of the time we got along very well, except some of us were not so tactful and charming when we became sleep deprived.

The instructors were professionals with extensive experience in Washington, D.C., and throughout the country. They were experts to say the least - - very intelligent, funny and tough.

At the end of the week, the leaders of the school rated us on our behavior and interaction as a group, and also how well we organized our campaigns. It was a great study in human dynamics. The candidate for my group did not win because we didn't have everything in written detail. Although we had a fine presentation, you couldn't bluff your way with these judges!

The candidate who did win was Jon Amores, the son of Drs. Diana and Tino Amores. Jon ran a great campaign and his people did an outstanding job of detailing every aspect. As most of you know, Jon is a candidate in Charleston for the House of Delegates. I'M SURE HE WILL WIN!!

The AMPAC Campaign Management School must be one of the best in the country. It taught me just how much is involved in successfully running for office. The reality is - - you need many people to help you, a substantial amount of money and total commitment.

I can't stress enough just how valuable an experience I think attending this school would be for any physician or Alliance member. Not only do you gain an inside look at the world of politics, you learn how to effectively campaign for candidates - - a critical lesson in medicine today.

Carole Scaring
WVSMA Alliance President

West Virginia State Medical Association Alliance

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Who we are

The West Virginia State Medical Association Alliance is a volunteer organization of physician, resident and medical student spouses. Also, retired and honorary members are actively involved in our organization. We are over 700 members strong, including members-at-large and 15 county/region alliance chapters. With each new member, we improve as an organization as the membership chain is lengthened and strengthened for the good of medicine. We are a part of a federated system of medicine with our national office, the American Medical Association Alliance Inc., in Chicago.

Our purpose

The WVSMAA was designed to assist in those programs of the West Virginia State Medical Association that improve the health and quality of life for people, to uphold the programs of the AMA Alliance, to promote health education, to encourage participation of volunteers in activities that meet health needs and to support health-related, charitable endeavors.

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New Members

We would like to welcome these 18 new members to the WVSMA:

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Raymond Coombe, MD
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Arturo Roa, MD
#3 Stonecrest Drive
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Richard Gobao, MD
300 Wedgewood Drive
Morgantown, WV 26505

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Special Memorial

IAN WILLIAM MARSHALL, M.D.

"There is a deep pathos in a life cut off in the promise of such rich fruit. He will be numbered among the inheritors of unfulfilled renown."

Sir William Osler

Osler's words reflect the thoughts of many upon hearing of the passing of Dr. Ian William Marshall. He died suddenly in his home in Morgantown on March 8, at the age of 30.

Ian was born in Morgantown on July 18, 1963, to Drs. Robert J. Marshall and Mabel M. Stevenson, who were then on the medical faculty at West Virginia University and now practice in Huntington. He pursued his studies at the Mercersburg Academy in Pennsylvania and Kenyon College in Ohio. In 1989, Ian returned to Morgantown and received his M.D. degree from WVU. His medical training included research in the Virology Laboratory at Marshall University School of Medicine, which culminated in a co-authored presentation at the 14th International Congress of Chemotherapy. He then completed four years of residency in diagnostic radiology at WVU Hospitals. Since 1993, he had devoted his skills in private practice in North Central West Virginia with Radiology Consultants Associated.

The influence of Ian's parents upon him was unmistakable. The elegance and strength of his mother and the regal dignity of his father provided" ... that education in virtue from youth upwards, which enables a man to pursue the ideal perfection" (Plato). Ian achieved that ideal, both personally and professionally. He was admired for his honesty and strength of character. In the words of his elder brother, Stephen, he possessed a serenity, a stability of mind and manner, and a maturity beyond his years. And at all times, he maintained a reserved dignity.

It was his infectious laughter, his love of life, his insight and thoughtfulness, and of course his trademark good nature and quick wit that his friends most valued. In fact, these are the virtues that made all of his friends consider Ian their best friend. If a man is measured by the effect he has on the sum of his friends, then Ian's virtues are truly boundless.

Ian is survived by his parents; his brother, Stephen R. Marshall, and his wife, Linda, of New York, N.Y.; his sister, Deirdre M. Marshall, M.D., and her husband, Anthony Wolfe, M.D., of Miami, Fla.; and his fiancee, Julia Chico, of Morgantown.

Ian will remain, for all of us, a cherished friend always.

Frederick J. Gabriele, M.D.
Pittsburgh, Pa.

Obituaries

Frederick H. Dobbs, M.D.

Dr. Fred H. Dobbs, 86, died April 3 at his home in Charleston after a long illness.

Dr. Dobbs was born in Wheeling and attended what is now West Virginia University when it was still a two-year school. He completed his medical degree at Rush Medical College at the University of Chicago in 1934, and then interned at Swedish Covenant Hospital in Chicago. His did his residency at Sibley Memorial Hospital in Washington, D.C.

Dr. Dobbs served six years in the U.S. Navy during World War II. He trained first in Pensacola, Fla., during the early years of the war and then became a flight surgeon assigned to the Marine Corps and stationed in the South Pacific.

In 1947, Dr. Dobbs moved to Charleston and began his practice as an obstetrician/gynecologist. He worked 32 years before retiring at the age of 71. In addition to being a member of the WVSMA, Dr. Dobbs was the founder of the American College of Obstetrics-Gynecology and a member of the AMA, and the American Association of Obstetrics-Gynecology.

A longtime member of St. John's Episcopal Church in Charleston, Dr. Dobbs helped found the Order of Jerusalem, a service group of lay ministers in the Episcopal Church. He was devoted also to Manna Meal, a program which he was instrumental in starting at St. John's to feed anyone in need.

"He'd probably want to be remembered more for his work with Manna Meal than anything else," his son, Thomas Dobbs said. "He even went to the church and worked every day when he retired. He used to clean the tables off and help serve the food. He thought Manna Meal was great," he added.

Dr. Dobbs is survived by his wife, Pauline Dobbs; sons, Dr. Frederick H. Dobbs II of Titusville, Fla., and Thomas Dobbs of Charleston; sister, Kathryn Wedemyer of West Palm Beach, Fla.; and two grandchildren.

The family suggests memorial contributions to Manna Meal, 1105 Quarrier St., Charleston, W.Va., 25301.

Pastor C. Gomez, M.D.

Dr. Pastor C. Gomez, 73, of Williamson, died November 21 at his home.

Born in the Philippines, Dr. Gomez was a graduate of the University of Sancti Thomar. He was a past coroner of Mingo County. A member of the WVSMA since 1981, Dr. Gomez was also a member of the Mingo County Medical Society, the First Presbyterian Church of Williamson and the Lions Club.

Survivors include his son, Douglas Gomez of Webster, N.Y.; daughters, Kristina Sculac of Bethleham, Pa.; and five grandchildren. He was preceded in death by his parents, Pastor Pineda and Natividad Cezzteno Gomez.

West Virginia Medical Journal

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Front Cover

Tulips in the gardens at the home of Paul and Nancy Hill of Charleston dance in the spring breeze. Photo courtesy of *Nancy Hill,* managing editor of the *West Virginia Medical Journal.*

Travel medicine for West Virginians

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Abstract

***Preparation for overseas travel often involves a prolonged search for expertise and necessary vaccinations that can be a formidable challenge to patients and physicians alike. Many primary care providers find themselves ill-equipped to provide up-to-date information for travel to undeveloped countries where there may be risks of diarrhea, malaria and other exotic diseases. However, basic travel advice can easily be incorporated into most practices with the help of regularly updated reference materials such as the CDC's* Health Information for International Travel.**

More advanced assistance along with the necessary vaccinations is available throughout West Virginia at a number of travel clinics which are discussed in this article. Through greater awareness of travel issues and timely referral, physicians may expedite their patients' travel plans while safeguarding their health abroad.

Introduction

The world is rapidly becoming a closer-knit community and therefore a more inviting place for travel in spite of its political woes. More people than ever seem to be venturing abroad for business, tourism, education, and church or relief work. Travelers are also becoming more adventurous and more prone to stray off the beaten path to destinations in the Third World.

While Europe is still popular, it is not at all unusual to have your patients aspire to an African safari, a trekking adventure in Nepal, or a boat tour into an Amazonian rain forest. So, it is inevitable that even doctors practicing in West Virginia will have to deal with the "travel bug" when it bites their patients.

Possible case situation

What advice do you give your patient, a 40-year-old diabetic pastor, when he informs you that he will be taking his recently pregnant wife and two young children on a short-term mission to Africa which will involve travel through several undeveloped countries? Are you ready to answer his questions such as:

What sort of diseases could he and his family could catch over there?

What should they take to keep from getting diarrhea?

What can they take to reduce the risk of malaria?

What happens if they get sick?

What insect repellents should be brought along?

How can his diabetes be managed if there is no electricity to keep his insulin cold?

And finally the clincher -- what shots are needed and where can you get them?

Solutions

You would not be alone if you felt overwhelmed by such a barrage of questions during a patient's office visit. Granted that this example of the diabetic pastor is complex and some health recommendations should have already been made if there was a sending agency, but it's best to be prepared to answer the most basic travel questions.

The answers to most of these types of questions can be found in the Center for Disease Control's *Health Information for International Travel* published by the U.S. Dept. of Health and Human Services, Public Health Service, for $6. This yellow paperback provides a wealth of information that no office can really afford to be without. Of course, travel advice changes rapidly with time, so the CDC regularly updates its information. There is a 24-hour, seven-day-a-week traveler's hotline available (404-332-4559) which provides the most current guidelines (1).

It is especially important to realize that the advice and vaccines you might have received on your trip 10 years ago are probably no longer valid for the same destination today. For instance, oral typhoid vaccination is now replacing the painful injections of the past, and malarial prophylaxis recommendations have been completely revised with the inexorable spread of chloroquine-resistant strains.

Other travel risks

Always advise your patients to avoid casual overseas sexual contact since it may carry a high risk of transmitting Hepatitis B or AIDS, not to mention other sexually-transmitted diseases (1). However, if sexual contact does occur, condoms must be used; but, individuals need to realize that even they do not provide total protection.

Surprisingly, serious infectious disease is much less of a threat to travelers today than it was in the past except in the most unhygienic of circumstances. Studies of traveler mortality have shown that infectious diseases accounted for a tiny proportion of overseas deaths (less than 1% in some series) and that cardiovascular disease and accidents, especially motor vehicle accidents, are the real killers (2). In other words, wearing a seat belt, driving defensively, and remembering to pack the nitroglycerin will undoubtedly save more lives than travel vaccinations and pills. Be sure to put these risks into perspective for your patients since it is unlikely anybody else will do this for them.

Preventive measures

In spite of these facts, concern still focuses on infectious disease, which indeed remains an important source of morbidity, if not mortality, for travelers. The most common travel questions can be lumped into three main categories that can be covered only briefly in this article: traveler's diarrhea, malaria prophylaxis, and immunization recommendations.

It is more important to emphasize preventive measures than have the patient develop a false sense of security from having had his shots and carrying a few pills. In underdeveloped countries, it is prudent to avoid drinking unboiled/untreated water and eating uncooked, room-temperature food or fruit (unless you have peeled it yourself). It is helpful to remember the classic warning: "Boil it, cook it, peel it or forget it." Even brushing your teeth with tap water or having ice in your drink (alcoholic or otherwise) could result in a few days of misery.

In the tropics, and particularly in malarious regions, insect repellents are a must. Limit outdoor exposure after dusk and wear protective, light-colored clothing with long sleeves and pants if you must be out. Spraying clothing with permethrin (Permanone) also helps, as do insect repellents containing diethyl toluamide (deet) (4). Excessive use of deet-containing repellents on children's skin may cause neurotoxicity, so moderation is in order. If there are no reliable window screens, a permethrin-treated mosquito net is worth its weight in gold even if there is no malaria in the region.

For trips to Third World countries, it is best to prepare a comprehensive travel kit containing the following items:

1) An International Certificate of Vaccination to document vaccines received (available at travel clinic),
2) Malaria prophylaxis medication,
3) Deet-containing insect repellent,
4) Water purification tablets,
5) Oral rehydration salt packets,
6) Traveler's diarrhea treatment medication -- possibly also bismuth subsalicylate (Pepto-Bismol) for prophylaxis or early treatment,
7) Imodium AD for relief of diarrhea symptoms,
8) Sunscreen,
9) Bandaids,
10) Spare pair of eyeglasses or prescription for same,
11) Ample supply of regularly-prescribed medications,
12) Thermometer,
13) Analgesic of choice,
14) Antiseptic for minor wounds,
15) Antifungal powder,
16) Toilet paper (remove roll to pack); and
17) Motion sickness medication if necessary.

Traveler's diarrhea

Infectious diarrhea is likely to be foremost on your patient's mind and with good reason. Even with precautions, 20%-50% of travelers in areas of high risk are likely to contract it, often within the first week of arrival (5). Fortunately, it is usually a benign and self-limited disease, but even so it can ruin a short trip and seem anything but benign at the time.

Preventive dietary restriction remains the best policy, and the CDC has recommended that routine medical prophylaxis be avoided by those in good health. Nevertheless, people entering high-risk areas for short but critical visits may wish to protect themselves with bismuth subsalicylate or Pepto-Bismol (6). Two chewable tablets four times a day (with meals and at bedtime) for up to three weeks can decrease the incidence of diarrhea up to 60% (7). Longer courses than three weeks are not recommended and the traveler must also realize this medication could discolor the tongue or stool and even cause tinnitus. Sensitivity to aspirin, peptic ulcer, and bleeding disorders are also contraindications. Although antibiotics such as sulfamethoxazole trimethoprim and doxycycline have been used as effective prophylactic agents, they have potentially serious side-effects that may not justify their widespread use in a healthy population.

It is reasonable, though, to give your patient treatment options to use if and when diarrhea occurs. Here again, bismuth subsalicyclate is a reasonable initial choice along with loperamide (Imodium AD) and an oral-hydration solution. High fever or dysentery are not common with traveler's diarrhea, but if they occur, loperamide should be discontinued and medical attention sought. Severe diarrhea is often treated today with sulfamethoxazole (800 mg.) and trimethoprim (160 mg.) twice daily for three days, but because of increasing resistance problems, ciprofloxacin (Cipro) 500 mg. twice daily for three days may eventually become the drug of choice in adults, unless they are pregnant (8).

Malaria prophylaxis

Malaria risk assessment is critical for travelers in less developed areas and, unfortunately, prophylaxis is becoming more complicated as chloroquine resistance spreads. Mefloquine (Lariam) 250 mg. weekly, starting one week prior to departure and continuing for four weeks after return, is now the best available protection in much of the world (9).

Currently, chloroquine can only be used in the Middle East (including Egypt), Hispanola, and Central America west of the Panama Canal, but it can sometimes be combined with other agents if mefloquine is contraindicated. Contraindications to mefloquine include pregnancy, children under 15 kg., neuropsychiatric problems including seizures, certain cardiac medications (including beta-blockers, calcium-channel blockers, quinidine), and possibly the need to maintain excellent spatial discrimination (e.g. pilots) (9). In parts of Asia, especially Thailand, Cambodia and Myanmar (Burma), malaria has managed to become resistant to mefloquine, making daily doxycycline the best prophylactic agent in the border areas of this region (9).

It is all too evident that today's options for malaria protection are increasingly limited, and those available are mostly unsatisfactory for pregnant women and children. There is no such thing as total protection with any present regimen, so sulfadoxine/pyrimethamine (Fansidar) is often carried for presumptive malaria treatment in the event that high fever and chills do develop in a remote region. Of course, medical treatment should be sought as soon as possible after Fansidar is taken and the prophylactic agent continued.

Many popular tourist destinations in countries where malaria is present may be malaria-free (e.g. Nairobi and Rio de Janeiro), and travelers may not be at much risk if they remain in more civilized areas and minimize exposure to the night-feeding Anopheles mosquito (1). Recommendations are subject to change, and travel clinics are usually better equipped than most individual practitioners to decide where and when to use malaria prophylaxis.

Immunizations

Perhaps the most frequently encountered problem with travel immunizations is not allowing enough time prior to departure to complete the optimal series. Four weeks of time is sufficient for most travelers with reasonably complete, routine U.S. immunization records. Many older Americans lack basic immunizations such as tetanus, however, and this problem can easily be remedied in the average physician's office before referral to the travel clinic. Although certain vaccines are mandatory for

crossing borders, it is not necessary to vaccinate the traveler against every disease in the region unless that individual is truly at risk.

There are many vaccine options today for travelers, but not all are equally effective or necessary. Cholera vaccine, for instance, has a brief limited effect and is usually not recommended by the World Health Organization (1,4). Some vaccines such as Japanese B Encephalitis are only used in very special cases, such as when individuals are spending more than one month in rural, rice-growing regions in Asia (4). The very low risk of travelers contracting this mosquito-borne disease makes it unnecessary for most Asian travel. Similarly, meningococcal vaccine is useful only in areas having seasonal epidemics such as sub-Saharan Africa (December - June) or in pilgrims traveling to Mecca (4).

Other vaccines such as typhoid and yellow fever have a broader application and may well be mandatory. Typhoid vaccine is now started two weeks prior to departure as an oral dose every other day for a total of four doses. Oral typhoid and polio are both live vaccines and should be given at least two weeks apart. A polio booster is recommended if the patient is traveling to an area at risk. Inactivated polio vaccine is preferred for adults (over 18 years old) if prior polio vaccination status is uncertain (1).

Yellow fever vaccine is live and is available only at approved yellow fever vaccination centers. (Yellow fever and cholera vaccination should be at least three weeks apart.) In West Virginia, these vaccination sites are located in Morgantown, Huntington and Charleston. Current vaccination requirements are listed by country in the CDC's *Health Information for International Travel* and are subject to change.

Hepatitis prevention

Immune globulin is necessary to protect against Hepatitis A when travel to areas of very poor sanitation is likely. The adult dose is 2 ml. IM for a visit under three months and 5 ml. if staying longer than three months (with doses to be repeated every five months) (4).

There is no risk of AIDS transmission with immune globulin prepared in the U.S., and pregnancy is not a contraindication. Although the enterically-spread Hepatitis A is a very real threat, Hepatitis B is much less likely to be acquired as it is transmitted by contact with blood or by sexual activity. Hepatitis B vaccine (3 doses) is recommended for health care workers and people who anticipate living in highly endemic areas for more than six months, especially if they are likely to have sexual contacts or receive local medical/dental care (4).

Clinics in West Virginia

Travel medicine or emporiatrics, as it is sometimes called, is obviously a very complex discipline. Even with the extensive reference materials, most physicians would welcome the opportunity to refer patients to a regional travel center after answering some of their basic questions. With timely referral, such a facility could sort out all the variables, consider contraindications, give current advice, and supply the necessary vaccines. Some live virus vaccines such as yellow fever are available at only a few locations, so in many cases the patient needs to be referred regardless.

Several clinics are now available in West Virginia which offer comprehensive travel advice and vaccinations. The University Health Service of West Virginia University in Morgantown offers complete travel counseling along with a wide array of vaccinations including yellow fever, cholera, typhoid (oral and injectable), tetanus-diptheria, polio, Hepatitis B, rabies, meningococcus, Japanese encephalitis, MMR, and immune globulin. The address and phone number for this facility is: WVU Health Service Travel Clinic, Box 9247, Robert C. Byrd Health Sciences Center of WVU, Morgantown, WV 26506; (304) 293-2311.

In Charleston, travel services are provided at two locations by the Kanawha-Charleston Health Department. The main office is located at 108 Lee Street, Charleston, WV 25301; (304) 348-0700; and the Public Health Unit is housed at the Charleston Area Medical Center (CAMC) at 3101 MacCorkle Ave., S.E., Charleston, WV 25304; (304) 348-8160. Vaccines at these sites include yellow fever, cholera, typhoid, tetanus-diptheria, polio, Hepatitis B, rabies (if special ordered), MMR, and immune globulin.

The Cabell-Huntington Health Department provides counseling and vaccines for yellow fever, cholera, typhoid, tetanus-diphtheria, polio, Hepatitis B, MMR, rabies, and immune globulin at 1336 Hal Greer Blvd., Huntington, WV 25701; (304) 523-6483. Also in Huntington, the Travel Clinic of University Family Physicians is able to provide detailed travel advice based on itinerary as well as survival skill instruction for those venturing into very remote or dangerous regions. This clinic is run by Dr. John Walden of Marshall University and is located at 1616 13th Ave., Huntington, WV 25701; (304) 525-0275.

Infectious disease specialists (some with tropical medicine experience) are available at Marshall University, CAMC and West Virginia University to assist with specific disease concerns or unusual illnesses that patients may bring back from overseas. WVU's MARS line (1-800-WVA-MARS) provides easy, rapid access to such expertise.

In conclusion, many patients and their physicians become frustrated or even confused while attempting to negotiate the travel-preparation maze. It is hoped that travel medicine, always a somewhat arcane field, will become somewhat less so with the help of these resources within our state.

Acknowledgement

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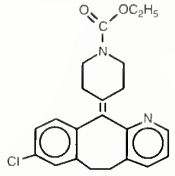
Loratadine is a white to off-white powder not soluble in water, but very soluble in acetone, alcohol, and chloroform. It has a molecular weight of 382.89, and empirical formula of $C_{22}H_{23}ClN_2O_2$; its chemical name is ethyl 4-(8-chloro-5,6-dihydro-11*H*-benzo[5,6]cyclohepta[1,2-*b*]pyridin-11-ylidene)-1-piperidinecarboxylate and has the following structural formula:



CLINICAL PHARMACDLDGY Loratadine is a long-acting tricyclic antihistamine with selective peripheral histamine H_1-receptor antagonistic activity.

Human histamine skin wheal studies following single and repeated 10 mg oral doses of CLARITIN Tablets have shown that the drug exhibits an antihistaminic effect beginning within 1 to 3 hours, reaching a maximum at 8 to 12 hours and lasting in excess of 24 hours. There was no evidence of tolerance to this effect after 28 days of dosing with CLARITIN Tablets.

Pharmacokinetic studies following single and multiple oral doses of loratadine in 115 volunteers showed that loratadine is rapidly absorbed and extensively metabolized to an active metabolite (descarboethoxyloratadine). The specific enzyme systems responsible for metabolism have not been identified. Approximately 80% of the total dose administered can be found equally distributed between urine and feces in the form of metabolic products after 10 days. The mean elimination half-lives found in studies in normal adult subjects (n = 54) were 8.4 hours (range = 3 to 20 hours) for loratadine and 28 hours (range = 8.8 to 92 hours) for the major active metabolite (descarboethoxyloratadine). In nearly all patients, exposure (AUC) to the metabolite is greater than exposure to parent loratadine.

In a study involving twelve healthy geriatric subjects (66 to 78 years old), the AUC and peak plasma levels (Cmax) of both loratadine and descarboethoxyloratadine were significantly higher (approximately 50% increased) than in studies of younger subjects. The mean elimination half-lives for the elderly subjects were 18.2 hours (range = 6.7 to 37 hours) for loratadine and 17.5 hours (range = 11 to 38 hours) for the active metabolite.

Loratadine, dosed once daily, had reached steady-state by the fifth daily dose. The pharmacokinetics of loratadine and descarboethoxyloratadine are dose independent over the dose range of 10 to 40 mg and are not significantly altered by the duration of treatment.

In the clinical efficacy studies, CLARITIN Tablets were administered before meals. In a single-dose study, food increased the AUC of loratadine by approximately 40% and of descarboethoxyloratadine by approximately 15%. The time to peak plasma concentration (Tmax) of loratadine and descarboethoxyloratadine was delayed by 1 hour with a meal. Although these differences would not be expected to be clinically important, CLARITIN Tablets should be administered on an empty stomach.

In patients with chronic renal impairment (Creatinine Clearance ≤ 30 mL/min) both the AUC and peak plasma levels (Cmax) increased on average by approximately 73% for loratadine; and approximately by 120% for descarboethoxyloratadine, compared to individuals with normal renal function. The mean elimination half-lives of loratadine (7.6 hours) and descarboethoxyloratadine (23.9 hours) were not significantly different from that observed in normal subjects. Hemodialysis does not have an effect on the pharmacokinetics of loratadine or its active metabolite (descarboethoxyloratadine) in subjects with chronic renal impairment.

In patients with chronic alcoholic liver disease the AUC and peak plasma levels (Cmax) of loratadine were double while the pharmacokinetic profile of the active metabolite (descarboethoxyloratadine) was not significantly changed from that in normals. The elimination half-lives for loratadine and descarboethoxyloratadine were 24 hours and 37 hours, respectively, and increased with increasing severity of liver disease.

There was considerable variability in the pharmacokinetic data in all studies of CLARITIN Tablets, probably due to the extensive first-pass metabolism. Individual histograms of area under the curve, clearance, and volume of distribution showed a log normal distribution with a 25-fold range in distribution in healthy subjects.

Loratadine is about 97% bound to plasma proteins at the expected concentrations (2.5 to 100 ng/mL) after a therapeutic dose. Loratadine does not affect the plasma protein binding of warfarin and digoxin. The metabolite descarboethoxyloratadine is 73% to 77% bound to plasma proteins (at 0.5 to 100 ng/mL).

Whole body autoradiographic studies in rats and monkeys, radiolabeled tissue distribution studies in mice and rats, and *in vivo* radioligand studies in mice have shown that neither loratadine nor its metabolites readily cross the blood-brain barrier. Radioligand binding studies with guinea pig pulmonary and brain H_1-receptors indicate that there was preferential binding to peripheral versus central nervous system H_1-receptors.

Clinical trials of CLARITIN Tablets involved over 10,700 patients who received either CLARITIN Tablets or another antihistamine and/or placebo in double-blind randomized controlled studies. In placebo-controlled trials, 10 mg once daily of CLARITIN Tablets was superior to placebo and similar to clemastine (1 mg BID) or terfenadine (60 mg BID) in effects on nasal and non-nasal symptoms of allergic rhinitis. In these studies, somnolence occurred less frequently with CLARITIN Tablets than with clemastine and at about the same frequency as terfenadine or placebo. In studies with CLARITIN Tablets at doses 2 to 4 times higher than the recommended dose of 10 mg, a dose-related increase in the incidence of somnolence was observed. Therefore, some patients, particularly those with hepatic or renal impairment and the elderly, may experience somnolence.

In a study in which CLARITIN Tablets were administered at 4 times the clinical dose for 90 days, no clinically significant increase in the OTc was seen on ECGs.

INDICATIDNS AND USAGE CLARITIN Tablets are indicated for the relief of nasal and non-nasal symptoms of seasonal allergic rhinitis.

CONTRAINDICATIONS CLARITIN Tablets are contraindicated in patients who are hypersensitive to this medication or to any of its ingredients.

PRECAUTIDNS **General**: Patients with liver impairment should be given a lower initial dose (10 mg every other day) because they have reduced clearance of CLARITIN Tablets.

Drug Interactions: The coadministration of a single 20 mg dose of CLARITIN Tablets (double the recommended daily dose) and a 200 mg dose of ketoconazole twice daily to 12 subjects resulted in increased plasma concentrations of loratadine (180% increase in AUC) and its active metabolite, descarboethoxyloratadine (56% increase in AUC). However, no related changes were noted in the OTc on ECGs taken at 2, 6, and 24 hours after the coadministration of loratadine and ketoconazole. Also, there were no significant differences in clinical adverse events between CLARITIN Tablet groups with or without ketoconazole.

Other drugs known to inhibit hepatic metabolism should be coadministered with caution until definitive interaction studies can be completed. The number of subjects who concomitantly received macrolide antibiotics, cimetidine, ranitidine, or theophylline along with CLARITIN Tablets in controlled clinical trials is too small to rule out possible drug-drug interactions. There does not appear to be an increase in adverse events in subjects who received oral contraceptives and CLARITIN Tablets compared to placebo.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: In an 18-month oncogenicity study in mice and a 2-year study in rats, loratadine was administered in the diet at doses up to 40 mg/kg (mice) and 25 mg/kg (rats). In the carcinogenicity studies, pharmacokinetic assessments were carried out to determine animal exposure to the drug. AUC data demonstrated that the exposure of mice given 40 mg/kg of loratadine was 3.6 (loratadine) and 18 (active metabolite) times higher than a human given 10 mg/day. Exposure of rats given 25 mg/kg of loratadine was 28 (loratadine) and 67 (active metabolite) times higher than a human given 10 mg/day. Male mice given 40 mg/kg had a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) than concurrent controls. In rats, a significantly higher incidence of hepatocellular tumors (combined adenomas and carcinomas) was observed in males given 10 mg/kg and males and females given 25 mg/kg. The clinical significance of these findings during long-term use of CLARITIN Tablets is not known.

In mutagenicity studies, there was no evidence of mutagenic potential in reverse (AMES) or forward point mutation (CHO-HGPRT) assays, or in the assay for DNA damage (Rat Primary Hepatocyte Unscheduled DNA Assay) or in two assays for chromosomal aberrations (Human Peripheral Blood Lymphocyte Clastogenesis Assay and the Mouse Bone Marrow Erythrocyte Micronucleus Assay). In the Mouse Lymphoma Assay, a positive finding occurred in the nonactivated but not the activated phase of the study.

Loratadine administration produced hepatic microsomal enzyme induction in the mouse at 40 mg/kg and rat at 25 mg/kg, but not at lower doses.

Oecreased fertility in male rats, shown by lower female conception rates, occurred at approximately 64 mg/kg and was reversible with cessation of dosing. Loratadine had no effect on male or female fertility or reproduction in the rat at doses of approximately 24 mg/kg.

Pregnancy Category B: There was no evidence of animal teratogenicity in studies performed in rats and rabbits. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, CLARITIN Tablets should be used during pregnancy only if clearly needed.

Nursing Mothers: Loratadine and its metabolite, descarboethoxyloratadine, pass easily into breast milk and achieve concentrations that are equivalent to plasma levels with an AUC_{milk}/AUC_{plasma} ratio of 1.17 and 0.85 for the parent and active metabolite, respectively. Following a single oral dose of 40 mg, a small amount of loratadine and metabolite was excreted into the breast milk (approximately 0.03% of 40 mg over 48 hours). A decision should be made whether to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother. Caution should be exercised when CLARITIN Tablets are administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children below the age of 12 years have not been established.

ADVERSE REACTIONS Approximately 90,000 patients received CLARITIN Tablets 10 mg once daily in controlled and uncontrolled studies. Placebo-controlled clinical trials at the recommended dose of 10 mg once a day varied from 2 weeks' to 6 months' duration. The rate of premature withdrawal from these trials was approximately 2% in both the treated and placebo groups.

REPORTEO ADVERSE EVENTS WITH AN INCIDENCE OF MORE THAN 2% IN PLACEBO-CONTROLLEO ALLERGIC RHINITIS CLINICAL TRIALS

PERCENT OF PATIENTS REPORTING

	LORATADINE 10 mg OO n = 1926	PLACEBO n = 2545	CLEMASTINE 1 mg BID n = 536	TERFENADINE 60 mg BIO n = 684
Headache	12	11	8	8
Somnolence	8	6	22	9
Fatigue	4	3	10	2
Ory Mouth	3	2	4	3

Adverse event rates did not appear to differ significantly based on age, se or race, although the number of non-white subjects was relatively small.

In addition to those adverse events reported above, the following adver events have been reported in 2% or fewer patients.

Autonomic Nervous System Altered salivation, increased sweatin altered lacrimation, hypoesthesia, impotence, thirst, flushing.

Body As A Whole Conjunctivitis, blurred vision, earache, eye pai tinnitus, asthenia, weight gain, back pain, leg cramps, malaise, chest pai rigors, fever, aggravated allergy, upper respiratory infection, angioneurot edema.

Cardiovascular System Hypotension, hypertension, palpitations, syn cope, tachycardia.

Central and Peripheral Nervous System Hyperkinesia, blepharospasn paresthesia, dizziness, migraine, tremor, vertigo, dysphonia.

Gastrointestinal System Abdominal distress, nausea, vomiting, flatu lence, gastritis, constipation, diarrhea, altered taste, increased appetit anorexia, dyspepsia, stomatitis, toothache.

Musculoskeletal System Arthralgia, myalgia.

Psychiatric Anxiety, depression, agitation, insomnia, paroniria, amnesi impaired concentration, confusion, decreased libido, nervousness.

Reproductive System Breast pain, menorrhagia, dysmenorrhea, vaginiti

Respiratory System Nasal dryness, epistaxis, pharyngitis, dyspne nasal congestion, coughing, rhinitis, hemoptysis, sinusitis, sneezing, bror chospasm, bronchitis, laryngitis.

Skin and Appendages Dermatitis, dry hair, dry skin, urticaria, rash, pru ritus, photosensitivity reaction, purpura.

Urinary System Urinary discoloration, altered micturition.

In addition, the following spontaneous adverse events have been reporte rarely during the marketing of loratadine: peripheral edema; abnormal he patic function, including jaundice, hepatitis, and hepatic necrosis; alopeci seizures; breast enlargement; erythema multiforme; and anaphylaxis.

DRUG ABUSE AND DEPENDENCE There is no information to indicate tha abuse or dependency occurs with CLARITIN Tablets.

OVERDOSAGE Somnolence, tachycardia, and headache have been re ported with overdoses greater than 10 mg (40 to 180 mg). In the event c overdosage, general symptomatic and supportive measures should b instituted promptly and maintained for as long as necessary.

Treatment of overdosage would reasonably consist of emesis (ipeca syrup), except in patients with impaired consciousness, followed by the ad ministration of activated charcoal to absorb any remaining drug. If vomitin is unsuccessful, or contraindicated, gastric lavage should be performe with normal saline. Saline cathartics may also be of value for rapid dilutio of bowel contents. Loratadine is not eliminated by hemodialysis. It is no known if loratadine is eliminated by peritoneal dialysis.

Oral LD_{50} values for loratadine were greater than 5000 mg/kg in rats an mice. Doses as high as 10 times the recommended clinical doses showe no effects in rats, mice, and monkeys.

DOSAGE AND ADMINISTRATIDN Adults and children 12 years of age an over: One 10 mg tablet daily on an empty stomach.

In patients with liver failure, 10 mg every other day should be the start ing dose.

HOW SUPPLIED CLARITIN Tablets, 10 mg, white to off-white compresse tablets; impressed with the product identification number "458" on on side; and "CLARITIN 10" on the other; high density polyethylene plastic bot tles of 100 (NDC 0085-0458-03). Also available, CLARITIN Unit-of-Use pack ages of 14 tablets (7 tablets per blister card) (NDC 0085-0458-01) and 3 tablets (10 tablets per blister card) (NOC 0085-0458-05); and 10 x 10 table Unit Oose-Hospital Pack (NOC 0085-0458-04).

Protect Unit-of-Use packaging and Unit Dose-Hospital Pack tron excessive moisture. Store between 2° and 30°C (36° and 86°F).

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Ohio County members pleased with their first mini-internship

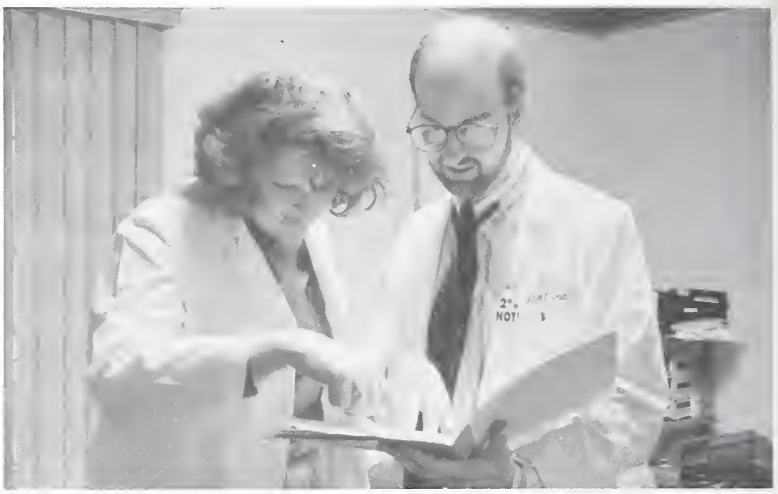
Nine interns, representing a variety of occupations in the Wheeling community, participated in the Ohio County Medical Society's first mini-internship in March. This program gave interns the chance to experience a normal day with members of the society. Both the interns and the doctors involved were extremely positive about their interactions, especially OCMS President Dr. Terry Elliott.

"I think the mini-internship is the best program our society has participated in during the past few years," Dr. Elliott said. "The goodwill and mutual understanding that it achieved is invaluable. Now, the members of the OCMS that participated and the community leaders who were the interns can communicate so much more effectively. This is not just because now we now know each other on a personal basis, but because we all appreciate and understand so much better about what is involved in each others' professions."

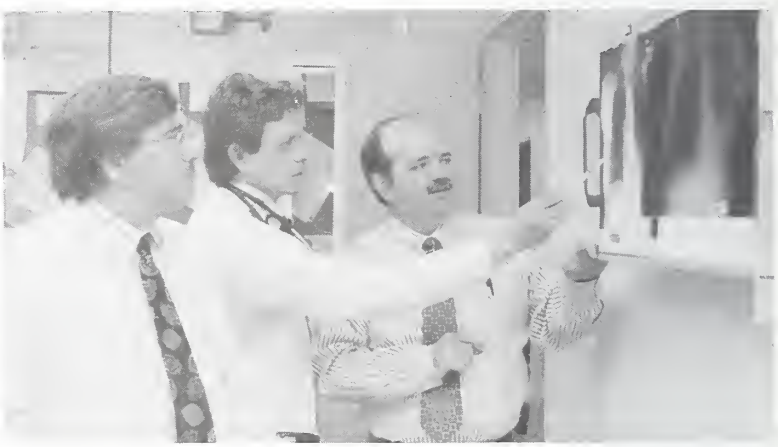
OCMS began their mini-internship with an orientation on March 20. The following day, the interns observed one certain physician as he/she performed routine office visits, hospital rounds and surgery. Interns were given beepers overnight in case their physician was called in for an emergency. A breakfast was then held in order to evaluate the program and give the interns and physicians a chance to comment.

"All of the comments that were given at the debriefing breakfast were so favorable that we plan on having another program within six to 12 months," Dr. Elliott said. "Many of the physicians who were unable to participate the first time are very eager to have the chance to have an intern. In addition, the interns all agreed that they would like to have at least two full days with their physicians, so we will be expanding the format of the program next time."

OCMS is the second county medical society to host a mini-internship program. Kanawha County Medical Society has had two programs and Cabell County Medical Society had their first program this month.

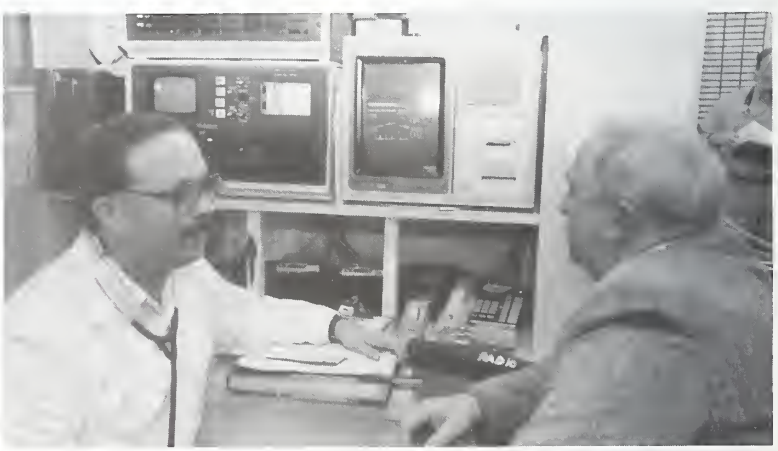


Family Practitioner Dr. Michael Fortunato explains some of the paperwork that emcompasses his day to intern Nicole Blanc, a reporter with WVPR.



Howard Monroe (left), talk show host for WOMP Radio, observes as resident Dr. Joe Durkalski (right) and Dr. Terry Elliott, family practitioner and director of the family practice residency program at Wheeling Hospital, discuss X-ray results.

Judy Romano, M.D., enjoyed sharing the rewards of pediatrics with intern Diane Vargo, a journalist for the *Wheeling News-Register*.



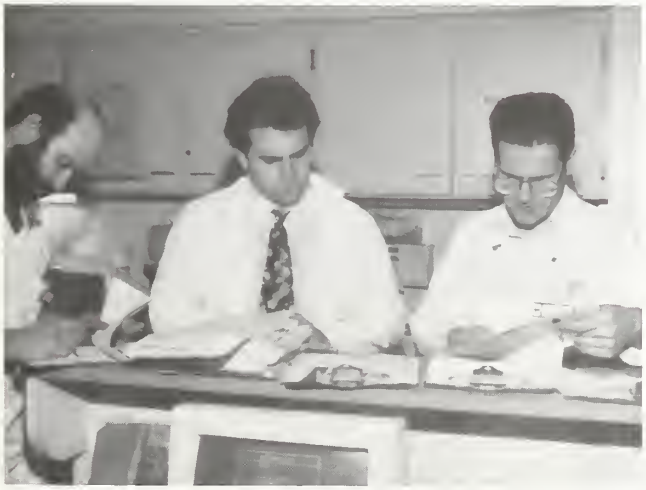
Dr. Max West, an emergency medicine physician, discusses a patient's treatment plan with Wheeling Fire Chief Cliff Sligar.

After observing Dr. Linda Linger perform a C-section, intern Diane Vargo admires the newborn in the nursery.

In the operating room, Wheeling Mayor Jack Lipphardt observes as Dr. Phil Polack anesthetizes a patient's broken thumb so a pin can be placed in it after a skiing accident.

Wheeling Councilman Tim McCormick looks on as Dr. William Strauch, an ophthalmologist, examines a patient's eyes for signs of glaucoma.

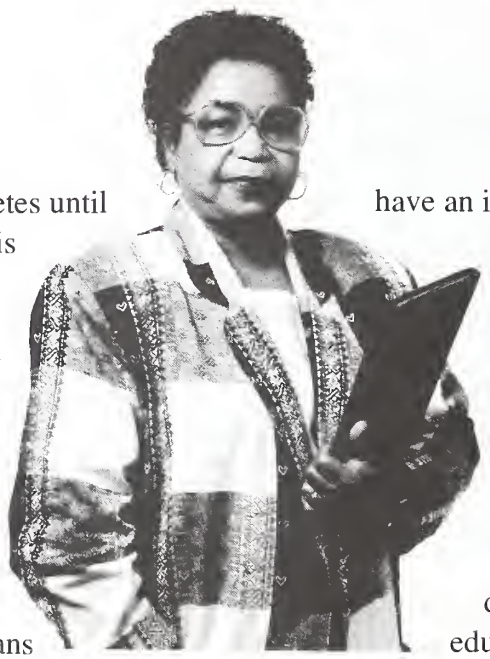
Clyde Campbell, Ph.D., president of West Liberty State College, watches Internist Dr. Angelo Georges check a patient's blood pressure.



Casey Swaney, a journalist with the *Times Leader* in Martins Ferry, Ohio, compares different insurance forms with Dr. Bruce Walmsley.

Larry Jones, Ph.D., superintendent of Ohio County Schools, and Dr. Carl Kite, discuss an X-ray of a patient's skull.

Ruth Ferguson lost her sight, but didn't lose her life.



Ruth did not know she had diabetes until she began to lose her sight. She is one of 14 million Americans with diabetes. Unfortunately, more than half do not know they have it because diabetes can strike silently. Like Ruth, many will first learn about diabetes when treated for one of its complications – amputation, kidney disease, blindness, heart disease or stroke. Black Americans have an increased risk of developing diabetes and should know the early warning signs of frequent urination, unusual thirst, extreme hunger, frequent infections or blurred vision.

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The treatment of intracranial lesions with stereotactic radiosurgery

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Abstract

Stereotactic radiosurgery is a new method of delivering a high dose of megavoltage, ionizing radiation therapy to a localized area in the brain in a single session. A substantial variety of intracranial lesions can be treated with the use of a stereotactic head frame and set up of tertiary collimators on an existing linear accelerator. This state-of-the-art technique has been used since June 1992 at the Robert C. Byrd Health Sciences Center of West Virginia University in Morgantown. Radiosurgery treatment has been well tolerated by all 24 patients treated thus far.

Introduction

Radiosurgery is defined as a non-invasive method to stereotactically deliver a high dose of megavoltage, ionizing radiation to a localized area in the brain in a single session. This technique was developed by Lars Leksell, M.D., a neurosurgeon in Stockholm, Sweden, and it utilizes a gamma knife machine which has 201 Cobalt-60 sources with a total activity of 60 kilolcuries mounted on a spherical shield weighing 18,000 kg.

Presently, there are 51 installed gamma knife machines in the world with 17 units in the United States. This system requires construction of a space with shielding that, in addition to the cost of the unit, can bring the total amount to more than $3 million just to begin operating a gamma knife.

An alternative approach that achieves the same result is to use a linear accelerator by adding a tertiary collimator and taking advantage of its ability to emit a beam of X-rays while moving in an arc around the patient. Combining a series of arcs, each with the table in a different position, produces a small region of convergence where the dose is very high, while the surrounding normal tissues receive a very low dose of radiation. This is the same effect produced by the gamma knife and the start-up costs are usually only 10 percent of those necessary for a gamma knife or even less.

There are currently more than 50 accelerator-based radiosurgery units in the United States, including the unit located in the Radiation Oncology Department at the Mary Babb Randolph Cancer Center in Morgantown.

Materials and methods

The stereotactic radiosurgery unit at WVU consists of a stereotactic ring and accessories, a set of circular collimator and computer software obtained from Leibinger, a German neurosurgery supplier. A DEC 3100/48 computer system is being used to run the treatment planning software. The actual treatment is carried out on a Siemen's linear accelerator using 15 MeV X-rays.

Since June 1992, 24 patients have been treated by radiosurgery in the Robert C. Byrd Health Sciences Center of WVU in Morgantown (Table 1). On the day of the radiosurgery procedure, the patient is admitted to the Same Day Care Unit in Ruby Memorial Hospital. The stereotactic frame is placed on the patient's head early in the morning and stereotactic CT scans are taken.

Table 1.

Diagnosis	Number of patients
Meningiomas	6
Single Brain Metastasis	6
Multiple Brain Metastases	8
Craniopharyngioma	2
Acoustic Neuroma	1
Pituitary Adenoma	2
Total	24

The CT scans usually involve serial 2 millimeter cuts throughout the entire brain. Typically, there are 40 to 50 transverse images for each scan. This CT data is transferred to the radiosurgery planning computer and the CT coordinates are transformed into stereotactic coordinates using the STP program. The target volume and the critical areas such as optic nerve, optic chiasma, eyes, brain stem and others are outlined on the CT images.

The goal of a radiosurgery treatment plan is to keep exposure to the eloquent areas of the brain below the safe limits, but at the same time give

Table 2. PROTOCOL FOR QUALITY ASSURANCE OF THE LINAC PRIOR TO TREATMENT

The physicist performs the following quality assurance steps on the LINAC equipment prior to each radiosurgery treatment session:

1. Install the stereotactic collimator apparatus in the tray holder of the LINAC. Set the standard collimator to a field size of 5 x 5 cm.

2a. The LINAC will be run in "rotation" mode to check the accuracy of the dose delivered in representative arches. The monitor units delivered will be expected to equal the number of monitor units required (+/-3%).

2b. Check the gantry and table isocenter and laser beam alignment.

3. Mount the ring holder onto the LINAC table.

4. Place patient on the treatment table and fasten the ring in the ring holder.

5. Attach positioning apparatus to ring.

6. "Zero" positioning indicators.

7. Set the indicators to match target coordinates obtained from the stereotactic treatment plan.

8. Move the table so the lasers match the position indicators.

9. Remove positioning apparatus from the ring.

10. Place the fiducial plates to the ring and take two double exposure port films. Run computer analysis of these films. The coordinator of the beam intersection must agree with the target coordinator from the treatment plan within 1 mm. before treatment can proceed.

the tumor a lethal dose. Adjustments in the treatment plans are made until the entire team agrees that it is appropriate. The treatment planning process takes three or four more hours depending upon the complexity of the case.

Once the treatment plan is approved, a series of quality assurance tests are conducted to assure the accuracy of the linear accelerator for radiosurgery (Table 2). Following the satisfactory completion of the quality assurance procedures, the patient is placed on the treatment table. The patient's head ring is clamped in place positioned so the target coincides with the isocenter (the common center of rotation of the gantry and treatment table), and orthogonal ports (PA and lateral) are taken.

These films are then digitized into the computer and analyzed using one part of the STP program. This analysis gives X, Y, and Z coordinates of the target which must agree with the coordinates from the treatment plan within one millimeter before treatment can begin.

A typical radiosurgery plan consists of five to seven arcs focusing on the stereotactically identified intracranial target (Figure 1). Each arc is between 120 to 180 degrees (Figure 2). The arcs are separated by moving the treatment table around the isocentric area. Each treatment arc takes two to three minutes of linear accelerator time to deliver a dose of 250 to 350 cGy to the treatment volume. Thus, a typical radiosurgery plan consisting of six arcs takes about 20 to 25 minutes of the machine time to deliver a dose of 1,500 cGy over the selected target. Most frequently, an 80 percent isodose line is selected to mark the border of the treatment volume.

When the treatment is complete, the frame is removed from the patient's head and he or she is observed overnight after the radiosurgery treatments.

Clinical results

Six patients with solitary brain metastasis were treated by radiosurgery to 1,500 cGy by the 6 arc technique at the Mary Babb Randolph Cancer Center. Three patients died of metastases in the lungs, liver and other organs, and three patients are still alive.

The follow-up CT scans of the brain in all of these patients demonstrated excellent tumor control. Figures 3-6 demonstrate CT scans of a patient with single brain metastasis from lung carcinoma with some shrinkage in the lesion after external beam radiotherapy to the whole brain with 3,000 cGy in 10 fractions and complete disappearance of the lesion after radiosurgery.

Eight patients had multiple lesions in the brain. Two lesions in five patients and one lesion in three patients were selected for treatment by radiosurgery because of their location in very critical areas. All these patients had been treated by external beam radiotherapy to the brain prior to the radiosurgery. Five patients died of progression of metastases in the bones, lungs, and other organs, and the three other patients are still alive. The follow-up CT scans of the brains of all the patients demonstrated regression of the lesions treated by radiosurgery.

Meningiomas varying in size from 28 millimeters - 48 millimeters in diameter have also been treated. An average dose of 1,800 cGy was delivered to the 80 percent isodose line. All of these patients are alive and subsequent CT scans after the treatment have demonstrated marked shrinkage in the lesions. None of the patients experienced any undue side effects of radiosurgery. In addition, the patients with acoustic neuroma, pituitary adenoma and craniopharyngioma have been treated and are doing well. Their follow-up CT scans indicated marked decrease in the tumor.

Radiosurgery has been well tolerated in all of our patients. Although the number of patients is small and the followups had only been conducted for one year, none of the patients had neurological deficits or brain necrosis requiring surgical intervention. Only one patient had generalized mild seizures which were controlled with Dilantin. We had made every effort to limit the dose to the optic apparatus, brain stem, pituitary, and other critical parts of the brain to 800 cGy, which is well tolerated.

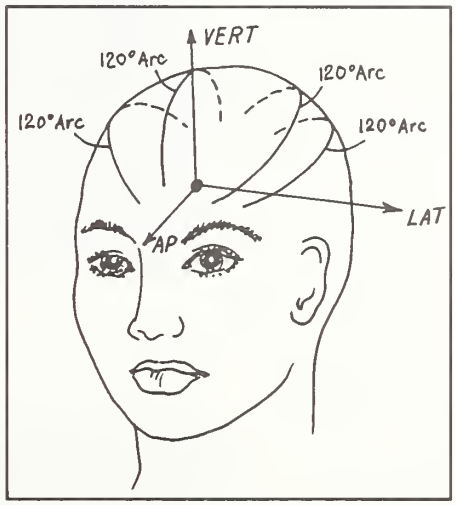

Figure 1.

Discussion

Stereotactic radiosurgery has been a very effective technique for controlling intracranial vascular malformations. Lunsford et al (4) at the University of Pittsburgh School of Medicine treated 251 patients with cerebral malformations with radiosurgery, and the outcome was complete obliteration in 85% - 100% of patients with lesions less than 4 cm^3, and 58 percent in the lesions between 4 cm^3 - 10 cm^3.

Surgical resection remains the main treatment for intracranial meningiomas. Management of patients with recurrent disease or with residual tumors is still a problem. Surgery may be very difficult in some meningiomas due to their location, and surgical morbidity and mortality may be high.

Management of intracranial meningiomas by external beam radiation therapy has also been controversial. Meningiomas are ideal tumors for radiosurgery because they are usually well demarcated, do not invade the adjacent brain tissues, and are well demonstrated on the CT and MRI scans. Kondziolka (6) reported 65 patients treated with radiosurgery, with 16 of the tumors located in the cavernous sinus regions. There were no immediate side effects, and the actuarial two-year growth control was found to be 95 percent.

Brain metastases develop in 40 to 50 percent of patients dying of cancer, and almost 40 to 50 percent of patients with brain metastases have solitary lesions. If the patients are untreated, they have a median survival of four to six weeks. Patients may survive 16 to

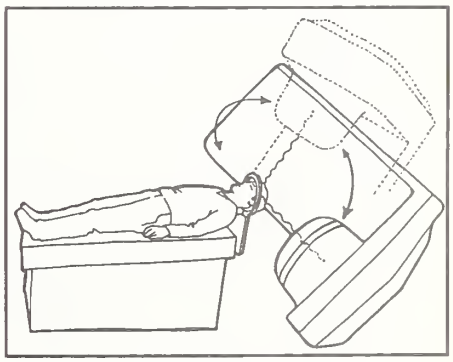

Figure 2.

Figure 3.

Figure 4.

20 weeks if given whole-brain irradiation, and surgery may be beneficial in a small number of patients.

In spite of whole-brain radiotherapy with or without surgery, the recurrence rate is high. Fuller et al (2) treated 47 brain metastases in 27 patients at Stanford by radiosurgery. They were able to achieve a radiographic local control rate of 88 percent.

Acoustic neuromas are very disabling conditions with hearing loss, ataxia, tinnitus, trigeminal sensory loss, and facial weakness. Although microsurgery has been the treatment of choice in unilateral tumors in young and healthy patients, radiosurgery is an alternative treatment and the preferred option in patients with recurrence after microsurgery and in patients who have sufficient medical problems to make surgery unacceptable. Linskey et al (3) treated 101 patients with acoustic neuromas with stereotactic radiosurgery and obtained a current tumor control rate of 97 percent.

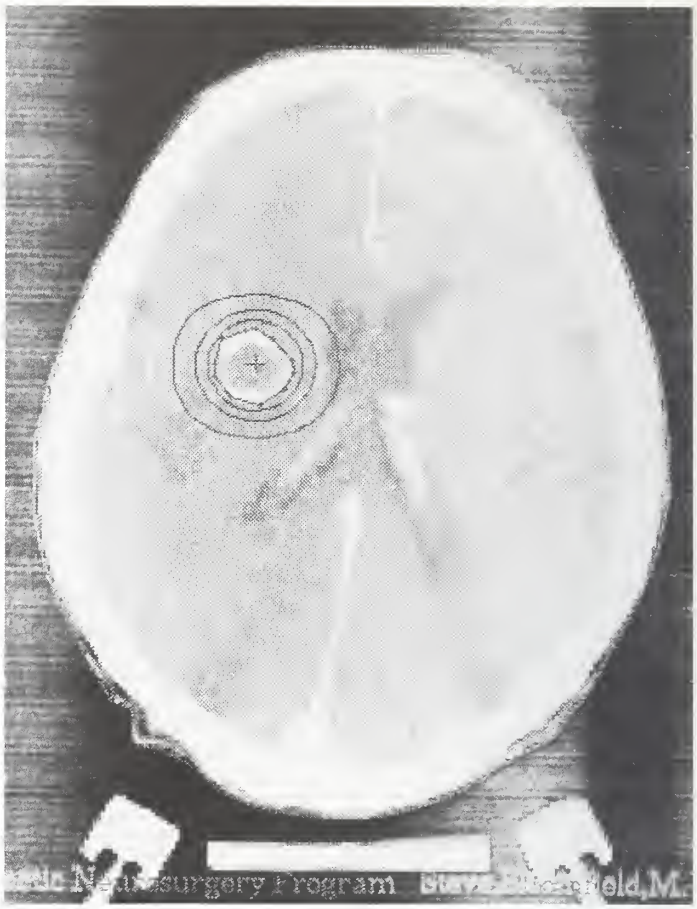

Figure 5.

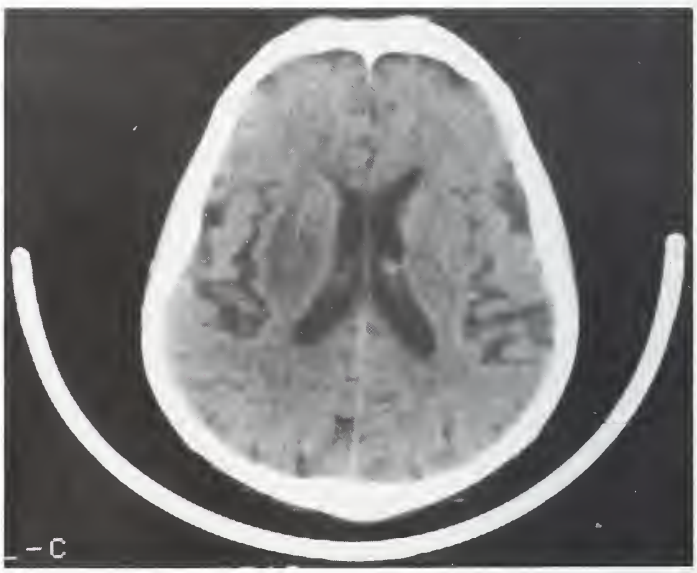

Figure 6.

In conclusion, stereotactic radiosurgery is a very new method to deliver ionizing radiation therapy in a large variety of intracranial lesions in a single session. It is a very effective treatment for arteriovenous malformations, acoustic neuromas, meningiomas, malignant glial tumors, metastatic brain lesions and many other brain lesions.

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Treatment of spastic gait in cerebral palsy

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Abstract

The most common presentation of cerebral palsy is spastic diplegia, which in severe cases can impede nursing care and in less severe cases can impair a child's ability to move around with facility. A procedure has been developed to decrease spasticity in which there is selective section of portions of the dorsal roots L2-S2. In a series of such operations in 19 children with spastic diplegia, we were able to decrease their spasticity significantly with resultant improvement in motor function and self care. There were no significant complications and patient and family satisfaction was high. Our experiences further confirm existing evidence that this procedure is very helpful and highly recommended for selected children with spasticity due to cerebral palsy.

Introduction

Cerebral palsy (CP) is a condition of altered motor control due to central nervous system lesions created during prenatal or neonatal insults (1). It occurs in 2/1,000 births and is defined as non-progressive encephalopathy involving motor function. There are a variety of types of CP including dyskinetic (athetoid, dystonic) and spastic, which may be accompanied by problems in mentation, sensation, integration of function, and other neurologic impairments.

The spastic types of CP may involve one, all or any number of the four limbs, but spastic diplegia which involves both legs is the most common, affecting 58%-65% of victims (2,3). The usual clinical precursor of spastic diplegia is the occurrence of some degree of asphyxia in the premature infant.

The pathophysiology of this condition is subependymal, germinal matrix hemorrhage or leukomalacia related to hypoxia in the posterior periventricular white matter where corticospinal leg fibers descend. Ordinarily these fibers would exert an inhibitory influence on the level of motor tone established by intrinsic circuits in the spinal cord. Without this dampening influence, tone and reflex sensitivity are too high and spasticity results, especially in the legs.

Spasticity is defined as a velocity-dependent increase in resistance to passive stretch. This is accompanied by triggering of antagonistic muscles and failure of inhibition of these muscles. Hyperactive deep tendon reflexes are seen, as well as weakness, loss of dexterity, fatiguability, and release of flexor reflexes, as well as occasional balance problems. Stronger muscles overcome weaker ones, leading to contractures of muscles and joints with decreased range of motion.

Non-operative treatment of spasticity includes physical therapy to prevent or retard contractures, altering patterns of movement, and improving strength, as well as the use of the antispastic drugs baclofen and dantrolene (3). Orthopedic operations include lengthening or release of muscles and tendons as well as procedures involving bones. They remain important for contractures and deformities (3).

The evolution of neurosurgical treatment (1) began in 1898 when Sherington observed that division of posterior roots decreased tone in decerebrate cats. In 1913, Foerster reported treatment of spasticity by cutting the posterior roots from L2 to S2 (sparing either L4 or L5). Then in 1978, Fasano and colleagues achieved some success by performing surgery at the level of the conus and cut only the posterior rootlets which caused excessive reflex activity.

Peacock modified the procedure, using an L2-L5 laminectomy for exposure to identify the roots of the cauda equina where they exited the dura. Peacock has performed the procedure on both severely spastic patients, even if retarded, whose hygiene and comfort are impaired by severe spasticity; and also on intelligent and mobile patients whose lifestyles are compromised by spasticity and who may risk the problem of contractures.

In a series of articles since 1982 (1,4-10), Peacock and his colleagues have demonstrated that this procedure is efficacious in decreasing spasticity and that its effects persist. It has succeeded in facilitating care in the first group of patients previously described, and improving function in the second group. In the latter, improved hand function, bowel and bladder function, and even improved vocal function have been observed. Secondary improvements in behavior as well as increased growth and weight have also been suggested.

Side effects of this procedure have been minimal. On rare occasions, it has unmasked unrecognized weakness and occasionally caused some paresthesias which are almost invariably short-lived. This procedure's value has been noted by patients and families, and since 1985, it has been adopted in many American centers.

Peacock's results have been replicated by other groups (2,3,11,12). It has been suggested that the surgery should be carried out before children are 8 years old to enable non-walkers to walk (12). In a DATTA survey published in 1990, selective dorsal rhizotomy was judged safe (69% established or promising) and effective (69%) for patients with ambulatory potential, and safe (69%) and effective (61%) for patients without ambulatory potential (2). In this article, we report the results of treating our first 19 patients with this technique.

Methods

All potential candidates for surgery were examined by the neurosurgeon, pediatric neurologist and physical therapist at the same time. Initial evaluation included a history which concentrated on birth, orthopedic procedures and appliances, and functional level in activities of daily living. The level of the patients' abilities to care for themselves was evaluated on a scale of 7-1 as shown in Table 1.

After obtaining an average grade of their self-care abilities, we also inquired about wheelchair management and transfers, but found there were too many variables to make the information suitable for analysis. In addition, bowel and bladder control

Table 1. Levels of Ability of Self Care

No Helper

7 = Complete independence (timely, safely)

6 = Modified independence (device)

Helper

5 = Supervision

4 = Minimal assist (Child = 75%+)

3 = Moderate Assist (Child = 50%+)

Complete Dependence

2 = Maximal assist (Child = 25%+)

1 = Total assist (Child = 0%+)

were also assessed, as well as family support, funding and resources at home. (We have been able to secure support from state agencies.)

Physical examination included evaluation of spasticity, which interferes with function or care, and the presence of rigidity, dystonia, hypotonia, athetosis, ataxia or significant weakness in antigravity musculature since these latter conditions are contraindications to surgery. Contractures are noted and the findings are documented by videotape.

The following are other quantitative assessments which are performed:

1. **Muscle Tone:** The modified Ashworth scale (Table 2) was used to determine muscle tone in hip adductors, hamstrings, quadriceps, and plantar flexors, and an average of the four muscles on both sides obtained. Elbow flexors and elbow extensors were also examined.
2. **Range of Motion:** Passive range of motion of hip flexion, knee flexion, hip adduction and ankle dorsiflexion was compared to full range of motion (Table 3). The grades for four joints on both sides were averaged, and elbow extension was assessed using the same scale.
3. **Myotatic reflexes:** The brachioradialis, biceps, triceps, quads, hamstrings, ankle jerks, and hip adductor reflexes were tested and graded 0-4, with 2 being normal.
4. **Static postures:** Patients are scored (Table 4) on their independence in holding for 10 seconds the static postures of prone on elbows, four-point kneeling, short sitting, half kneeling and standing, and these scores are averaged.
5. **Transitional movements:** Patients are evaluated (Table 5) for level of independence and time to accomplish the transitional movements of quadruped kneeling to side sitting, sitting to standing, tall kneeling to half kneeling, and four-point kneeling to chair sitting, and these scores are averaged.
6. **Ambulatory ability:** The ability to ambulate 8 feet (Table 6) as well as to stairclimb is graded and recorded.

Table 2. Levels of Muscle Tone (After Ashworth and Bohannon)

0 = Hypotonic	--	less than normal, floppy
1 = Normal	--	no increase in muscle tone
2 = Mildly hypertonic	--	slight increase, 'catch' in limb movement or minimal resistance to movement through half of the range.
3 = Moderately hypertonic	--	more marked increase in tone through most of the range of motion but affected part is easily moved
4 = Severely hypertonic	--	considerable increase in tone, passive movement difficult
5 = Extremely hypertonic	--	affected part rigid in flexion or extension

Table 3. Levels of Range of Motion

4 = Full range of motion

3 = 75% of full range of motion

2 = 50% of full range of motion

1 = 25% of full range of motion

0 = No motion at joint

Table 4. Levels of Static Posture

5 = Child independently maintains posture

4 = Requires use of own unilateral upper extremity support

3 = Requires use of own bilateral upper extremity support

2 = Requires continued support by another person

1 = Child must be held in position

0 = Child cannot be so positioned

Surgery is carried out through a laminectomy, L1-L2 across S1. Once the dura is opened, the motor roots of L4, L5 and S1 are identified on one side. The sensory roots are isolated and divided into three to seven rootlets. Each rootlet is stimulated to see if this causes excessive reflex movement. Those that do are cut, although one rootlet at least is usually left at each level. Postoperatively, patients have been noted to maintain a flexion posture for several days and to have some hypersensitivity of the legs.

The patient undergoes intensive physical therapy after postoperative recovery. Comprehensive postoperative evaluations are carried out at six months and one year to obtain information about function. All patients and/or families are asked at six months and 12 months postoperatively to rate their satisfaction with the results of surgery. A four-level grading was used (unsatisfied, neutral, satisfied and very satisfied). Examinations, including the videotape, were repeated.

Table 5. Levels of Transitional Movements

5 = Independently completes transition without person, device or use of UEs against self for support

4 = Completes transition with intermittent balance support

3 = Completes transition but requires use of UEs against self

2 = Child uses furniture, device or person as object to assist self

1 = Child observably participates; therapist must assist

0 = Child does not participate; therapist performs the movement

Table 6. Levels of Ambulatory Abilities

5 = Functionally ambulatory without device

4 = Functionally ambulatory with device (name device)

3 = Ambulates but not for functional use (cruises)

2 = Has some method of locomotion

1 = Unable to locomote

Results

We evaluated 19 patients, ages 2 years to 10 years. There were 12 males and seven females. Nineteen had follow-up at 6 months, while 12 of these have completed 12-month evaluations (Table 7). Only one patient had unsatisfactory follow-up care due to irresponsible parents, and he did poorly.

Muscle tone was improved in 17 patients. Initially, there was a marked increase in tone, but after surgery the average was halfway between normal and slightly increased. This makes handling and positioning much easier for the patients and their caregivers.

Range of motion was improved in 17 patients. Two patients with improved tone did not have improved range of motion, while two patients did not have improved tone but did have improved range of motion. These differences might be related to the intensity of physical therapy after surgery.

Myotatic reflexes were hyperactive in all patients prior to surgery, and all

patients lost their myotatic reflexes after surgery. Reflexes remained diminished in all but two children who regained their hyperactive reflexes and did less well functionally.

Before surgery, the average patient required the use of both upper extremities to maintain a static posture, whereas, after surgery they required only one upper extremity for support. This meant they had freed an extremity for use which made them more independent. In terms of transitional movements, the patients changed from needing the assistance of someone else to assisting themselves with the use of furniture, devices, or persons to provide a stable support, a significant improvement.

The ambulatory skills of these patients were also greatly improved. The patients who were not ambulatory before the surgery, which was apparently due to the basic underlying lack of control, were now able to bear weight, which aided bone development and circulation in the legs and functionally improved their ability to transfer. Patients already walking had improvement in quality and speed, but only one of the patients who was unable to stairclimb gained this ability.

In terms of self care, the patients went from providing only 50% of their own care to providing 75% of their own care. No patient either gained or lost sphincter control, although we did not investigate this in detail.

Eighteen patients and families were very satisfied with the procedure, and one was satisfied.

Table 7. Postoperative Results in Cerebral Palsy Patients

		19 PATIENTS		12 PATIENTS	
		Pre-op	6-Months	6-Months	12-Months
Muscle Tone (0-5)	Mean	2.9	1.5	1.5	1.3
	SEM	0.2	0.7	0.1	0.1
	Better		17 (89%)		2 (17%)
	Same		2 (11%)		10 (83%)
	Worse		0		0
Range of Motion (0-4)	Mean	2.7	3.6	3.5	3.6
	SEM	0.1	0.5	0.2	0.5
	Better		16 (84%)		4 (33%)
	Same		0		6 (50%)
	Worse		3 (17%)		2 (17%)
Static Posture (0-5)	Mean	3.0	3.6	3.4	3.6
	SEM	0.3	0.2	0.3	0.9
	Better		16 (84%)		6 (50%)
	Same		2 (10%)		6 (50%)
	Worse		1 (5%)		0
Transitional Movement (0-5)	Mean	1.9	2.6	2.4	2.7
	SEM	0.3	0.4	0.4	0.4
	Better		12 (63%)		8 (67%)
	Same		5 (26%)		3 (25%)
	Worse		2 (10%)		1 (8%)
Ambulate (1-5)	Mean	2.7	3.2	3.0	3.3
	SEM	0.4	0.3	0.5	0.4
	Better		7 (39%)		3 (27%)
	Same		10 (56%)		8 (73%)
	Worse		1 (6%)		0
Self Care (1-7)	Mean	3.3	4.1	4.0	4.4
	SEM	0.5	0.5	0.6	0.5
	Better		14 (78%)		7 (63%)
	Same		3 (17%)		3 (27%)
	Worse		1 (6%)		1 (9%)

Conclusions

Our series confirms the reports of others concerning the helpfulness of selective dorsal root section for the spasticity of cerebral palsy. There was marked improvement in muscle tone and spasticity, and there were secondary functional gains such as static posture, transition, ambulation, self care and satisfaction, which obviously improved the quality of life.

It is obvious to us, as well as to other health care professionals who have performed larger series and statistical testing, that this operation should be performed early in life, probably any time after two years. This is the time period when the potential for relearning motor skills is highest and before orthopedic deformities occur which necessitate corrective procedures that can themselves lead to weakening of critical muscles. Early surgery can obviate the need for such procedures.

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A case report of multimodality therapy of bladder cancer

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Abstract

Recurrent transitional cell carcinoma of the bladder can pose many challenging treatment options. We present an unusual case requiring multiple forms of treatment and a discussion of these treatments.

Introduction

The primary goal in the treatment of transitional cell carcinoma (TCC) of the bladder is to achieve a cancer-free state, with preservation of the native bladder being a secondary goal. Treatment modalities for bladder cancer include surgical resection, radiation therapy, systemic and intravesical chemotherapy, and intravesical immunotherapy. A combination of these treatment modalities is often necessary to most effectively manage a patient's disease.

Documented resolution of invasive bladder cancer with topically applied intravesical chemotherapy has not been reported, but complete responses occur in about one third of the patients treated with cisplatinum-based combination chemotherapy. In contrast to the lack of efficacy with intravesical chemotherapy, complete responses with intravesical BCG immunotherapy have been verbally reported, but not well documented.

We present a case of a patient with recurrent TCC of the bladder who had an apparent complete response of muscle invasive TCC to intravesical BCG immunotherapy. Treatment with all four treatment modalities resulted in bladder preservation for 10 years before cystectomy ultimately became necessary.

Case report

An 85-year-old man who presented with Grade II superficial TCC of the bladder in 1981 was first managed by transurethral resection of the bladder tumor (TURBT). Superficial recurrences developed in 1982 and he was then treated with a six-week course of intravesical thiotepa.

In August 1986, diffuse carcinoma-in-situ (CIS) was discovered and this patient underwent immunotherapy with Bacille Calmette-Guerin (BCG). Follow-up in January 1987 revealed Grade III T3a disease localized to the dome, with resolution of the diffuse CIS. CT scan showed a thickened and irregular bladder wall with no evidence of lymphadenopathy.

This patient subsequently underwent a partial cystectomy and pelvic lymph node dissection in March 1987. The final pathology specimen was without evidence of disease. Urinary cytologies remained suspicious, but there were no recurrences until March 1989, when a papillary lesion near the right ureteral orifice and a patch of CIS were discovered. These were treated with intralesional interleukin-2 (IL-2) injections under an experimental protocol (2,000 units intralesionally weekly for four weeks and then monthly for five months), and the lesions responded well. CIS recurred in May 1990, and was treated with intravesical mitomycin.

A transurethral resection of a recurrent lesion in November 1990 revealed a Grade III, T2 lesion. He then underwent treatment utilizing another protocol with concomitant external-beam radiation and 5-fluorouracil (5-FU). A dose of 2,000 rads was delivered over two weeks with 5-FU being administered in a dose of 1,000 mg./m2/d. intravenously for 96 hours at the beginning of each course of 2,000 rads. Three cycles were given with a one-week rest period between each cycle.

Early follow-up showed a complete response until recurrence of a Grade III, Ta lesion and CIS in October 1991. Investigational therapy with intravesical Intron A (alpha-interferon) was then initiated, but early follow-up showed presence of T2 disease in January 1992. In March 1992, radical cystoprostatectomy with ileal conduit diversion was performed on this patient at the age of 85.

The final pathology report demonstrated one small focus of Grade III, T2 disease with no residual CIS. He has done well since and was without evidence of recurrence at his 12-month follow-up.

Discussion

Early management of superficical TCC of the bladder involves transurethral resection. Muscle-invasive disease in a surgical candidate is best treated by cystectomy. Treatment decisions become more difficult when patients develop multiple superficial recurrences despite treatment, or when minimal muscle-invasive disease occurs in patients who are not good surgical candidates or refuse cystectomy. For these patients, there are a variety of treatment options, though some of them are currently experimental.

During the first five years of this patient's disease, it remained superficial and was managed by TUR alone. When he presented with CIS in 1986, BCG immunotherapy was given intravesically. Response rates of CIS to BCG range between 68% - 82% with an average of 74% (1). It offers the best response rate of any intravesical agent currently available, since mitomycin C has a reported response rate of only 53% in CIS (2).

Partial cystectomy still has a role in patients with highly-localized bladder cancer (Stage T2-T3). The five-year survival rate in this group has ranged between 50% - 70% (3). It is certainly a very viable option for patients with localized muscle-invasive disease desiring a bladder-sparing procedure and is tolerated better than a cystectomy in high-risk surgical patients.

For both of these reasons, our patient underwent a partial cystectomy. Since the pathology report showed no evidence of cancer, it was either completely removed with TUR (which we considered unlikely), or eradicated secondary to the effects of BCG immunotherapy. We have heard numerous verbal reports and previously observed response of muscle-invasive TCC to intravesical BCG (4).

Interleukin 2 (IL-2) is a lymphokine produced by helper T-lymphocytes, which induces proliferation of activated T-lymphocytes including lymphokine-activated killer (LAK) cells. In 1984, Pizza and colleagues reported complete tumor regression in three of six patients with invasive bladder tumors who were treated with

intralesional injection of IL-2 (5). Sosnowski showed a significant reduction in tumor volume of murine TCC when the tumors were injected with IL-2 (P=.01)(6). In our current clinical trial, we have observed complete responses in injected tumors in three out of six patients. Two of these responding patients had muscle-invasive TCC, had failed multiple previous treatments, and were not candidates for radical cystectomy (7).

Radiation therapy alone for stage B2 to C disease only results in about a five-year survival rate of 25%. The radiosensitivity of tumor cells has been found to increase with 5-FU (8). Russell had a 45-month survival rate of 64% in 34 patients treated with 5-FU and radiation therapy as a bladder-sparing protocol (9). Patients with residual disease underwent cystectomy, while those with complete response were observed. Using a similar protocol, our patient received 6,000 rads in combination with 5-FU and had a complete response. Therefore, observation was continued.

Alpha-interferon is currently being studied in clinical trials. A Stanford-NCOG study reported a 32% complete response in 19 patients with CIS and a 25% complete response in 16 patients with papillary tumor when treated with intravesical alpha-interferon (10). In addition, Torti had four of eight patients with CIS achieve a complete response (11).

With the persistence of muscle-invasive disease despite multimodality therapy, our patient finally consented to undergo a recommended cystectomy. Pathology surprisingly showed only a small focus of Grade III muscle-invasive TCC of the bladder. All pelvic lymph nodes were negative for metastasis.

Conclusion

This case presentation demonstrates the natural course of a high-grade bladder tumor treated with several different regimens. We were able to extend the life of his native bladder by five years from the time of development of muscle-invasive disease and 10 years from the time of initial presentation.

There is suggestion that this patient had a complete response of muscle-invasive disease to BCG immunotherapy. In select patients who have failed standard therapies and who do not desire cystectomy, these are some (but not all) of the many treatment options currently available.

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_____

_____

_____

_____

Physician Name _____

(You must supply WVSMA member name to receive the member discount)

Registration Fee

1 WVSMA Member Physicians' Offices
$50 per person - Total :_____

1 Non-member Physicians' Offices
$125 per person - Total: _____

Make checks payable to the West Virginia State Medical Association. Payment must accompany form.

Mail form with total registration fee to:
WVSMA, PO Box 4106, Charleston, WV 25364

OUR AREA OF EXPERTIS

Cancer crosses all cultures and all nationalities without exception. So it stands to reason that the treatment and eventual cure of a condition experienced worldwide would require talent and intellect from around the globe.

That's why the planners of The Arthur G. James Cancer Hospital and Research Institute, a National Cancer Institute designated Comprehensive Cancer Center, set out to staff this promising medical center with the top researchers in their field, wherever they might be found. Their search resulted in a respected team of renowned specialists from all around the world.

However, this search would never have been successful without a highly attractive institution. Designed to provide the optimum environment for the development and application of effective cancer treatments, The James house remarkable research facilitie within the same building as a equally excellent treatment ce ter. Because the organization

ENERATION OF HOPE

VERS A LOT OF GROUND.

pproach to research is so inte-
rated, the lag time between labo-
atory breakthroughs and practi-
al application is dramatically
ecreased. Collaboration between research teams and clinical specialists of the Comprehensive Cancer Center, which are composed of University graduate programs in chemistry, biological sciences, pharmacy and veterinary medicine, has enabled research efforts to advance efficiently while benefiting from the resources of one of the nation's leading University medical programs.

Beginning with the very first blueprints, The James was designed to provide researchers with the facilities, technology and opportunity to conduct their best work. Today, it is a reality that is dedicated to offering hope to the current generation of cancer patients as well as the promise of eradication to those in the future.

THE OHIO STATE UNIVERSITY
JAMES CANCER HOSPITAL AND RESEARCH INSTITUTE

University, 300 West Tenth Ave., Columbus, OH 43210, 1-800-638-6996

We Agree.

Every state medical society, 64 medical specialty societies, and the American Medical Association agree that any health system reform legislation must contain the principles outlined in the letter below:

February 23, 1994

Dear Senator/Representative;

As physician organizations, we agree on the need for health system reform legislation that gives every American universal coverage for health care and effectively controls rising health costs, while ensuring quality patient care. These principles have been articulated by numerous medical organizations in their various health system reform policies and proposals. They remain the foundation of our legislative agenda, which is to enact laws that assure universal coverage for a standard set of health benefits, regardless of employment or economic status.

We believe that any measure adopted by the Congress should:

- Achieve universal coverage through a program where responsibility is shared by employers, individuals, and government in paying for health care coverage.
- Assure that every American has his/her choice of health plans, physicians, and other providers.
- Establish competition in the marketplace as a method of slowing the rate of growth in health spending.
- Give patients price and quality information to permit them to make informed decisions.
- Eliminate needless bureaucracy to create an efficient, streamlined, and coordinated system that minimizes red tape for patients, physicians, and other providers. Furthermore, health system reform must leave medical decision-making in the hands of physicians and their patients.

We believe that to enable physicians to best serve the interests of their patients, meaningful health system reform also must contain these elements:

- Significant antitrust relief that enables physicians to have a strong voice to balance the growing corporate and government domination of health care.
- Allow for physician-directed health care networks.
- Enhanced self-regulatory powers that would enable the profession to effectively police itself and its members without the threat of unwarranted litigation.

We also believe that major reforms in the professional liability system must be enacted, including a $250,000 cap on non-economic damages, limits on plaintiff attorneys' fees, and other measures that would minimize defensive medicine.

Every American will be affected by this legislation. The focus of policy-makers should be on how their decisions will affect patient care. Any system that raises significant barriers between patients and physicians will not provide the quality care our nation expects and deserves. We believe the above principles outline a framework for establishing constructive, effective, and needed health system reform.

Join your colleagues in your county and state medical societies and the AMA. And stand with the organizations that stand behind you.

American Medical Association
Physicians dedicated to the health of America

Aerospace Medical Association
Medical Association of the State of Alabama
Alaska State Medical Association
American Academy of Child & Adolescent Psychiatry
American Academy of Dermatology
American Academy of Facial Plastic & Reconstructive Surgery
American Academy of Family Physicians
American Academy of Insurance Medicine
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Orthopaedic Surgeons
American Academy of Otolaryngic Allergy
American Academy of Otolaryngology — Head & Neck Surgery
American Academy of Pain Medicine
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American Association of Clinical Endocrinologists
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American Association of Electrodiagnostic Medicine
American Association of Neurological Surgeons
American College of Allergy and Immunology
American College of Cardiology
American College of Chest Physicians
American College of Emergency Physicians
American College of Gastroenterology
American College of Legal Medicine
American College of Medical Quality
American College of Nuclear Medicine
American College of Nuclear Physicians
American College of Obstetricians and Gynecologists
American College of Physicians
American College of Rheumatology
American Fertility Society
American Gastroenterological Association
American Group Practice Association
American Medical Association
American Medical Directors Association
American Orthopaedic Association
American Orthopaedic Foot and Ankle Society
American Pediatric Surgical Association
American Psychiatric Association
American Roentgen Ray Society
American Society of Abdominal Surgeons
American Society of Addiction Medicine, Inc.
American Society of Anesthesiologists
American Society of Cataract and Refractive Surgery
American Society of Clinical Oncology
American Society of Clinical Pathologists
American Society of Colon and Rectal Surgeons
American Society for Dermatologic Surgery
American Society for Gastrointestinal Endoscopy
American Society of Hematology
American Society of Internal Medicine
American Society of Maxillofacial Surgeons
American Society of Plastic and Reconstructive Surgeons, Inc.
American Society for Therapeutic Radiology and Oncology
American Thoracic Society
American Urological Association
Arizona Medical Association, Inc.
Arkansas Medical Society
California Medical Association
College of American Pathologists
Colorado Medical Society
Congress of Neurological Surgeons
Connecticut State Medical Society
Contact Lens Association of Ophthalmologists, Inc.
Medical Society of Delaware
Medical Society of the District of Columbia
Florida Medical Association
Medical Association of Georgia
Hawaii Medical Association
Idaho Medical Association
Illinois State Medical Society
Indiana State Medical Association
Iowa Medical Society
Kansas Medical Society
Kentucky Medical Association
Louisiana State Medical Society
Maine Medical Association
Medical & Chirurgical Faculty of the State of Maryland
Massachusetts Medical Society
Michigan State Medical Society
Minnesota Medical Association
Mississippi State Medical Association
Missouri State Medical Association
Montana Medical Association
Nebraska Medical Association
Nevada State Medical Association
New Hampshire Medical Society
Medical Society of New Jersey
New Mexico Medical Society
Medical Society of the State of New York
North Carolina Medical Society
North Dakota Medical Association
Ohio State Medical Association
Oklahoma State Medical Association
Oregon Medical Association
Pennsylvania Medical Society
Radiological Society of North America
Renal Physicians Association
Rhode Island Medical Society
Society for Cardiovascular and Interventional Radiology
Society of Critical Care Medicine
Society for Investigative Dermatology, Inc.
Society of Nuclear Medicine
South Carolina Medical Association
South Dakota State Medical Association
Tennessee Medical Association
Texas Medical Association
Utah Medical Association
Vermont State Medical Society
Medical Society of Virginia
Washington State Medical Association
West Virginia State Medical Association
State Medical Society of Wisconsin
Wyoming Medical Society

Motivations

What gives our assailants the idea they can improve Medicine by degrading doctors? Most of us are smart enough to make a living doing something else which is not degrading and which will give some status. Recently, some doctors have started doing exactly that.

It is no secret that a very common motivation toward a career in Medicine is the opportunity to be the good guy, the giver, the one who wears the white hat. Young men and women are motivated to study, work and to put off establishing families by the lure of gaining status, respect and regard from the community and the patients they care for.

These thoughts come to mind when reading a newspaper account of Ralph Nader berating Senator Rockefeller for supporting some version of tort reform in Congress. Mr. Nader is reported to have given a statistic alleging that U.S. doctors are responsible for 80,000 deaths each year in hospitals alone. The source of this statistic is not cited. He added that it is "criminal" for doctors to refuse to perform certain operations because they fear malpractice litigation.

Who is to protect the public from the lies, distortions and fear engendered by the likes of Mr. Nader? We know the role of fear and anxiety in dissuading patients from seeking treatment. Unfortunately, Mr. Nader is an influential man to whom people listen as he mutters his dark warnings and implied advice to avoid medical care. He can be held personally responsible for an untold and immeasurable amount of pain, suffering and death via the fear-induced avoidance of needed medical care resulting from his comments.

It could be easily maintained that it is "criminal" for Mr. Nader or anyone to foster or promote pain, suffering and death on such a large scale. What government agency, what enlightened court will bring him to task? Who is to punish him and assess punitive damages for the pain and suffering *he* causes? If he were just a stockbroker lieing and offering bad, misleading or self-serving advice, the SEC would put him in jail or, at the very least, fine the firm that employed him. Is it just that our regulatory and punitive systems are only stirred to action if a definable number of dollars are involved?

Mr. Nader is not alone in characterizing doctors so badly. He is just one of the worst. His opinions and remarks damage not only the people he frightens away from medical care, but also those individuals considering a career in Medicine and the doctors already practicing who need just one more reason to try something else.

A major criticism of doctors by Mr. Nader and others for many years has been, "they make too much money." Anyone having an interest in the subject, however, would find that high income in Medicine is simply a byproduct of the work done -- rarely is wealth the primary goal of anyone entering Medicine. It is simply something that happens as a result of doctors' industry. Efficiency analysts looking at the productivity of doctors have consistently found that because other industries and professions lag so far behind, it is difficult even to name another in second place.

It is perhaps possible to attract another breed of applicants to Medicine, a breed akin to the security seekers in the U.S. Post Office or any other government bureau. It seems likely, however, that these too would decline and unwilling candidates might need to be conscripted into any of the proposed government-run medical services being considered in Washington.

An unlimited amount of money is inadequate to overcome the handicaps of undeserved criticism, abuse, vulnerability to suit, second guessing by review bodies and the awareness of a missing sense of dignity ordinarily expected to accrue as a result of one's efforts. If a government-dominated health care system comes to pass, the practice of Medicine will become a burdensome series of tasks accompanied by a sense of futility and of shame rather than a sense of pride -- futility over the impossibility of dealing with a deadening bureaucracy in any self-respecting way; and shame over having passively accepted such a situation.

It's likely too that in such circumstances, a trip to the doctor will be equally as burdensome and distasteful for anyone required to seek care. The bright spot, however, is that care will indeed be cheap.

– Stephen D. Ward, M.D.
Editor

In My Opinion

It's time for tort reform!

President Clinton's determination to enact national health care reform will ultimately rest on the efforts of individual state legislatures to create efficient, cost-effective, viable solutions. At the forefront of the debate on this issue will be the future of malpractice litigation.

Since 1979, total compensation paid by insurers for medical malpractice claims has risen 25 percent annually. Nationally, 900 new malpractice lawsuits are filed each day, with an average award of $300,000 (1). In West Virginia, there has been a 2,770 percent increase in the number of malpractice claims filed per year between 1980 and 1989, and over $123 million in awards has been paid out during this period (2). Since one-fourth of the cases have been dismissed or not been awarded damages, the legitimacy of many claims has come into question.

In a 1991 article in the *Journal of the Royal Society of Medicine,* J.S. McQuade stated that the "malpractice crisis" has disruptive but non-quantifiable effects such as impairing the doctor/patient relationship, lowering job satisfaction and morale, and damaging the professional relationships between doctors and lawyers. In addition, he stated that it contributes to the practice of "defensive medicine" in an attempt to avoid litigation, such that two-thirds of every doctor's practice expenses are the result of defensive measures! (3).

McQuade's conclusions are further strengthened by the American Medical Association's findings that 66 percent of doctors admit ordering more tests, and 70 percent order more consultations because of liability concerns. About 26 percent of physicians waste in excess of $100,000 (1). These intolerable figures amount to billions of dollars wasted annually.

The process of medical malpractice litigation is so time-consuming that lawyers rarely take a case unless damages are likely to reach at least $100,000. In addition, only 25 percent of each liability dollar awarded actually reaches a successful plaintiff because of excessive legal fees, paperwork, expert witnesses, etc. (4). Pure economics dictate that resulting higher malpractice insurance premiums, while absorbed to some degree by physicians, are mostly shifted to consumers via increased fees. We are simply feeding the system rather than ensuring injured individuals their deserved compensation.

In an attempt to resolve these inequities, the Department of Health and Human Services' Task Force on Medical Liability and Malpractice released 30 recommendations for state plans. In 1986, over 1,400 bills were introduced in the 44 state legislatures in an attempt to address the alleged liability insurance crisis. More than three-fifths of the states enacted some form of tort reform in that year (5). The West Virginia Medical Professional Liability Act of 1986 included a range of progressive measures including:

(1) The abolition of the locality rule and the ad damnum clause;
(2) The placement of a $1 million cap on "non-economic" damages in a claim;
(3) The provision for an expert witness in cases; and
(4) A statute of repose to limit the period of time a suit can be filed following an incident of negligence (6).

These modifications, however, have proved to be insufficient to curb the costs of health care, and have only affected a few cases. Stricter limitations are needed to control the growing problem, and I suggest the creation of a pre-trial screening panel consisting of a rotating jury of two physicians, two attorneys and an expert from the state health board. This would serve to encourage early settlement of meritorious claims while discouraging frivolous suits. The Massachusetts program finds about 50 percent of its cases to be unfortunate medical results rather than examples of negligence (7).

As another deterrent to nuisance suits, I propose to make the solicitation of a person with a personal injury claim a misdemeanor punishable by heavy fines. Michigan has had some success with this approach and even has a provision for six-months' imprisonment (8).

Another promising reform could be the creation of standardized practice guidelines for each specialty and procedure. All physicians who demonstrate compliance with the designated guidelines would not be liable for the outcome. To be allowed, suits must include an affidavit from a medical specialist stating that care deviated from the standards. By controlling the practice of defensive medicine and the fear of lawsuits, competent doctors would practice with confidence while incompetence could be discovered and rectified. This concept is discussed in President Clinton's original health plan, but it must be enforced and regulated at the state level.

Other postulated reforms may show considerable promise in the West Virginia system. A collateral source rule requiring recovery amounts to be reduced by the amount received from other sources could help reduce the average insurance premium. Limitations on contingency fees would greatly reduce the final amount of excessive claims. Absolute caps on the total damages awarded exist in 27 states and should be seriously considered in West Virginia.

The major obstacle to these proposed reforms, as other states have experienced, is the unwillingness of all sides to grant concessions. To derive a comprehensive solution, there must be a three-sided consensus among the health care providers, the trial lawyers, and the medical insurance companies. Lawyer-dominated legislatures must look beyond allegiance to their trial bar colleagues and realize the necessity for responsible legislative action.

Other states have demonstrated tremendous potential for cost-effective reform. Indiana instituted a barrage of tort reform measures that resulted in a 92 percent decrease in the incidence of malpractice claims (4). We now have the opportunity to establish a comprehensive malpractice litigation system under the auspices of a national health care scheme. A plastic Health Security Card will not provide health care to anyone. That responsibility falls on the dedicated health professionals of this great state.

Brian Caveney
Pre-Med Student
West Virginia University

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Editor's Note: Brian was a national finalist at the Truman Scholar Competition in March at the University of Michigan with this essay. He is a senior at WVU, who maintains a 4.0 G.P.A. in his double major of chemistry and biology. After he had been at WVU only two and a half years, he was accepted to the WVU School of Medicine, which he will be entering in the fall of 1995.

The Hospital Medical Staff Section 23rd Assembly Meeting

June 9-13, 1994 Chicago Marriott Hotel Chicago, Illinois

Interactive Dialogue with AMA Board of Trustees

HMSS representatives will not want to miss this year's AMA-HMSS Annual Assembly Meeting held on **June 9-13** in Chicago. Aside from the usual policy-related activities, representatives will have an opportunity to dialogue with the AMA Board of Trustees, hear the latest news and information from Washington, and learn the importance of and methods for physician involvement in health system reform.

The Friday education program hosts an impressive panel of speakers. From their remarks, representatives will learn: the impact of proposed legislation on the future practice of medicine; the kinds of managed care entities most likely to thrive; the ways to cope with health care delivery changes at the local level; the support needed to pass legislation on physician involvement in health system reform; the steps for developing a physician-directed health delivery network or plan; and the best methods for managing patient care and physician compensation in physician health plans.

Physician Involvement in Health System Reform

With health system reform legislation pending before Congress, state health system reform initiatives, and the rapid development of integrated delivery systems, it is vitally important that medical staffs mobilize to stand up and speak out for patients and the profession. The June Assembly meeting is no exception. Now perhaps more than ever before, HMSS representatives need to be involved in shaping the nation's future health care system.

HMSS past actions have made a difference. The AMA has incorporated many issues advocated by HMSS in its new health system reform proposal for action and model legislation. Basically, the draft bill:

- requires that health plans establish a medical staff structure with defined rights with regard to the plan's medical policy, utilization, quality and credentialing and management issues;
- expressly permits physicians to jointly present their views on any plan issue (without boycott or strikes) to plan management for discussion and negotiation;
- directly aids physicians in the creation of their own plans or networks to compete with large insurance companies;
- requires negotiation of new regulations with the profession before their announcement ; and
- expands the role and protection for the profession's accreditation, standard setting and medical society disciplinary functions.

Success will depend on unified physician support and action. Mark your calendar and plan to attend!

For more information please call 312 464-4754 or 464-4761

American Medical Association
Physicians dedicated to the health of America

At Annual Meeting

Flink Address to focus on preventive medicine

Richard S. Lang, M.D., M.P.H., F.A.C.P., head of the Section of Preventive Medicine at the Cleveland Clinic Foundation, will deliver this year's Edmund B. Flink Address on Friday, August 19 at the WVSMA's 127th Annual Meeting at The Greenbrier. Entitled "Prevention in the 1990s," Dr. Lang's lecture will begin at 9:30 a.m., during the First Session of the WVSMA House of Delegates.

Dr. Lang received his A.B. degree in biology from Harvard College and then obtained his medical degree at the University of Cincinnati in 1979. He completed a residency in internal medicine at the Cleveland Clinic Foundation from 1979-82, and during this time he also worked as a senior clinical instructor at Case Western Reserve University Medical School in Cleveland.

In 1982, Dr. Lang was named director of Affiliated Residency Programs at St. Vincent Charity Hospital and Health Center in Cleveland. He held this post for four years, and during this time he rejoined the faculty at Case Western as a senior clinical instructor, a position which he still holds today.

Since 1986, Dr. Lang has been a staff physician in the Department of General Internal Medicine at the Cleveland Clinic Foundation, where he was named associate director of the Internal Medicine Residency Training Program in 1989 and head of the Section of Preventive Medicine in 1990. In addition to these roles, Dr. Lang is currently on the faculty of the College of Medicine of Pennsylvania State University and of the Ohio State University College of Medicine.

A medical examiner for the FAA since 1986, Dr. Lang is certified by American Board of Internal Medicine, the American Board of Preventive Medicine in Occupational Medicine and the American Board of Internal Medicine in Geriatric Medicine. He is a fellow of the American College of Physicians, the American College of Preventive Medicine, and of the Royal Society of Medicine. Dr. Lang is also a master of the American College of Occupational and Environmental Medicine and holds memberships in several other national and state medical organizations.

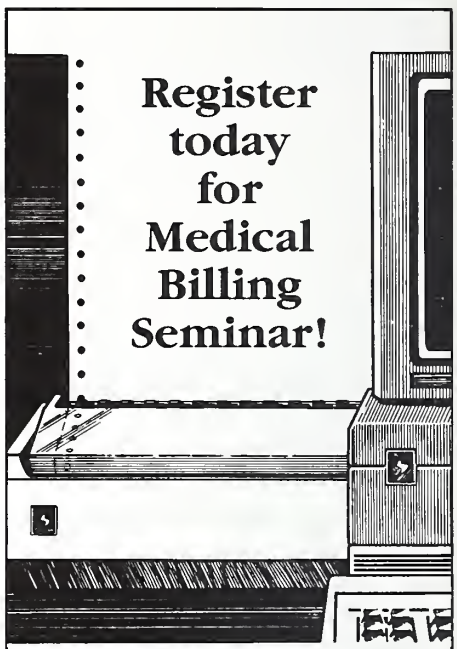
Dr. Lang

In addition to serving in many capacities on committees at the Cleveland Clinic Foundation, Dr. Lang is involved in many research projects. He has co-authored several books and chapters, as well as had articles printed in Southern Medical Journal, the Cleveland Clinic Journal of Medicine and other scientific publications.

The Edmund B. Flink Address was established by Derrick L. Latos, M.D., F.A.C.P., four years ago when he was president of the WVSMA, to honor Dr. Flink, a professor emeritus at WVU. Dr. Flink was chief of medicine for 16 years at WVU, and then in 1976 he became a Benedum professor who also served as an attending physician at the WVU Health Sciences Center until his death in 1992.

During his career, Dr. Flink had a major influence on medical education for many physicians in the state, including Dr. Latos who had been one of his students. Dr. Latos created the Flink Address not only to recognize Dr. Flink, but to provide an annual internal medicine lecture on a topic that had not only profound historic value, but also had current implications.

A registration form for this year's meeting appears on page 205. For other information concerning the WVSMA's Annual Meeting, contact Nancie Divvens at (304) 925-0342.



WVSMA is sponsoring a comprehensive workshop entitled the "1994 Medical Billing Seminar" for individuals responsible for filing claims in physicians' offices. This seminar will be held on Tuesday, June 28 from 8:30 a.m. - 4 p.m. in Flatwoods at the Days Inn, and it will feature representatives from Medicare, Medicaid, PEIA and the WVSMA.

Topics to be discussed at the meeting include claims documentation, fraud awareness, helpful hints for claims submission, keys to successful claims processing, simplifying the billing process, managed care options to PEIA insureds and common payment methodologies based on RBRVS.

Registration fees are $50 per person for staff members of WVSMA members, and $125 per person for non-members. Fees include lunch, two refreshment breaks, handout materials and a certificate of attendance.

Space is limited, so register early by mailing in the registration form which appears on page 195 in this issue of the *Journal.*

Two Lunch and Learn programs set for Annual Meeting

As a result of the extremely successful Lunch and Learn programs which were presented at last year's WVSMA Annual Meeting and at the WVMSA's Mid-Winter Clinical Conference, two more of these educational luncheons are planned for this year's WVSMA Annual Meeting at The Greenbrier in August.

The first Lunch and Learn is entitled "Managed Care . . . Minimizing the Risks," and it will be held on Thursday, August 18 from noon - 1:30 p.m. This session will feature Jan Woerth, Ph.D., president of J.K. Woerth, Inc., a medical management consulting firm with offices in Washington, D.C. and Florida. The second Lunch and Learn will take place the following day from noon - 1:30 p.m. and will focus on "The Shifting Winds of Quality Oversight." This program will be conducted by Harry S. Weeks Jr., M.D., president and director of the West Virginia Medical Institute, and Mark K. Stephens, M.D., principal clinical coordinator for the West Virginia Medical Institute's new Health Care Quality Improvement Program. Following the keynote addresses at both of these Lunch and Learn programs, other visiting dignitaries will join the speakers for panel discussions.

Brief biographical information about these three speakers begins below, and registration details about these luncheons are included on the WVSMA's Annual Meeting registration form which appears on page 205. For more details, contact Nancie Divvens at (304) 925-0342.

Dr. Woerth

Dr. Weeks

Dr. Stephens

Speakers highlighted

Dr. Woerth has been president of her own medical management consulting firm, J. K. Woerth, Inc., since 1986. She has presented over 450 seminars for state and local medical societies, hospitals, and medical specialty groups throughout the United States, and has provided consultation for private medical practices in 21 states.

In her consulting work, Dr. Woerth assists physicians and their staffs in maximizing third-party reimbursement, improving patient payments through better collection and billing techniques, improving cash flow by reducing the number of appeals made to Medicare and other insurance carriers, increasing office efficiency, reducing the chance of punitive action from Medicare audits, and developing personnel policy manuals. In addition to her own business, she is a staff associate with Conomikes and Associates, Inc.

Dr. Woerth is a contributing editor for the national Medicare publication and also writes a monthly practice management column for *Missouri Medicine*. She regularly contributes to medical publications in Michigan, Florida and Maryland.

Dr. Woerth received her doctor of philosophy degree in higher education administration from the University of Missouri in 1983. She also holds a master's degree in public health and health administration from the University of Oklahoma, a bachelor of arts in sociology and a bachelor of science degree in dental hygiene from the University of Nebraska.

Dr. Weeks is a native West Virginian who earned his bachelor of science degree from West Virginia University and his medical degree from the University of Maryland School of Medicine. After interning at Mercy Hospital in Baltimore, Dr. Weeks served as resident anesthesiologist at Ohio Valley General Hospital in Wheeling. Since 1956, he has been in private practice, first in Clarksburg and currently in Wheeling.

Lunch and Learn

During his career, Dr. Weeks has been active in a wide range of health care issues, including medical economics, health insurance, medical care foundations, health planning, medical education and medical licensure. Since 1973, he has been president and medical director of the West Virginia Medical Institute (WVMI), and established himself as a national leader in the fields of medical peer review and health care quality assurance. From 1968-76, Dr. Weeks was the liaison between the medical community and the governors of West Virginia. He continues to serve as health care resource person for Senator Jay Rockefeller.

Since November 1992, Dr. Weeks has been the project director for WVMI's External Peer Review Program (EPRP) contract with the Department of Veteran Affairs. In this capacity, he oversees a nationwide medical data abstraction and peer review program that encompasses 171 of the nation's VA medical centers and 50,000 episodes of patient care a year. Under Dr. Weeks' direction, the EPRP has become a national model for independent quality assessment in a multi-hospital system.

From 1977-80, Dr. Weeks served as president of the American Association of Professional Standards of Review Organization. Dr. Weeks is also a past president of the WVSMA, the West Virginia Society of Anesthesiologists, and the Ohio County Medical Society. He has served as an AMA delegate for the WVSMA, and as a member of the Medical Licensing Board of West Virginia. A fellow of the American College of Anesthesiologists, Dr. Weeks is also a diplomate to the American Board of Anesthesiologists.

Dr. Stephens is a native of Madison, W.Va., who earned his B.S. degree in biology from the University of Charleston in 1979, and his medical degree from the Marshall University School of Medicine in 1983. After serving his residency in internal medicine at West Virginia University's Charleston Division, Dr. Stephens was named medical director of the Charleston Area Medical Center's Drug and Alcohol Rehabilitation Unit.

In 1986, Dr. Stephens joined the Charleston Medical Group, an internal medicine practice. Two years later, he began practicing family and internal medicine with Healthplus in Kanawha and Putnam Counties, and also started serving as a physician reviewer for the West Virginia Medical Institute and as an associate professor of medicine at WVU's Charleston Division.

In August 1993, Dr. Stephens accepted the position of principal clinical coordinator for the WVMI's new Health Care Quality Improvement Program (HCQIP). Under HCQIP, the Health Care Finance Administration shifted the focus of Medicare Peer Review Organizations from identifying individual episodes of substandard care to addressing broad patterns of care and working cooperatively with hospitals and physicians to improve these patterns. As principal clinical coordinator, Dr. Stephens is overseeing this new quality improvement effort in West Virginia and is directly responsible for implementing WVMI's "Cooperative Improvement Projects."

A member of the American College of Medical Quality and the American College of Physicians, Dr. Stephens is board-certified in internal medicine, quality assurance, addictionology and geriatrics. He has admitting privileges at CAMC's Memorial, General, and Women's and Children's Divisions.

Radio Winners

The West Virginia Tobacco Control Coalition, of which WVSMA is a member, announced the winners of its "Sound Off Against Tobacco Use" radio public service announcement contest after receiving more than 1,100 entries from West Virginia students. Students in grades 5-12 wrote about either secondhand smoke or smokeless tobacco, and Philip Constantino of Jefferson High School in Charles Town; Vickie Martin of John Marshall High School in Glen Dale; Destiny Kelley of Taylor County Middle School in Grafton; and Aime Dizon of Williamson Junior High School; were selected to come to Charleston to produce their PSAs on West Virginia Public Radio. Chapman Printing Company donated certificates to recognize these winners and all of the participants.

Surprise Birthday

Seated in a wheelchair with a quilt and reading glasses, WVSMA Executive Director George Rider hams it up with a bottle of Metamucil, just one of the many gag gifts he received at the surprise party for his 60th birthday, which was given by his family and the WVSMA staff on April 5.

INTERPLAST seeking physicians, nurses

INTERPLAST WEST VIRGINIA, a non-profit, volunteer organization of plastic surgeons, anesthesiologists, pediatricians, nurses and support staff who travel to developing nations in the Third World to perform free reconstructive surgery on children with cleft lips and palates, burns and burn scar contractures, congenital anomalies, and traumatic injuries, is looking for new team members.

INTERPLAST currently has programs set up in over 17 countries throughout the world, and INTERPLAST WEST VIRGINIA sponsors two trips per year -- one to Ecuador and one to Peru. Teams usually stay for approximately two weeks and perform 120-150 surgeries.

For more information about the program, phone (304) 291-5663 or write to:

INTERPLAST WEST VIRGINIA
c/o David C. Fogarty, D.D.S., M.D.
165 Scott Ave., #206
Morgantown, WV 26505

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The West Virginia State Medical Association's

1994 Annual Meeting

August 17-20, 1994

The Greenbrier

White Sulphur Springs, West Virginia

Sign Up NOW!

Please be sure to make hotel reservations in advance by calling 1-800-624-6070. **The Greenbrier will fill up quickly because the State Fair will be going on during the same week.**

Space is being held at other area hotels/motels, contact the WVSMA at 304-925-0342 for more details. For your convenience, you may call the WVSMA office and register for the conference using your Visa or Master Card.

1994 Annual Meeting

Name _____

Address _____

City _____ State _____ Zip Code _____

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Conference Cost:	WVSMA member	$125 ___
	non-member	$175 ___
Additional:		
Thursday, Aug. 18		
Learn and Learn	member/non-member	$ 40 ___
(CME Credit)	spouse/student	$ 25 ___
Friday, Aug. 19		
Lunch and Learn		
(CME Credit)	member/non-member	$ 40 ___
	spouse/student	$ 25 ___
	TOTAL:	___

If paying by check, please send registration form and check to:
West Virginia State Medical Association
P.O. Box 4106, Charleston, WV 25364

Continuing Medical Education

Listed on this page are some of the upcoming CME programs which will be held in the state. Unless otherwise noted, the events are presented at the location under which they appear.

If you would like to have the CME programs offered by your institution or association for physicians printed in the *Journal* or obtain more details about the meetings listed, please contact Nancy Hill, managing editor, at 925-0342.

Robert C. Byrd Health Sciences Center of WVU - Charleston

June 2

(Seminar) "ABC's of Caring for HIV-Infected Patients," Elizabeth A. Funk, M.D.

June 16

(Seminar) "Pediatric Update," Naser Tolaymat, M.D.

June 21

(Seminar) "Management of Salivary Gland Disorders," (sponsored by The Eye and Ear Clinic of Charleston and the Dept. of Surgery), Robert E. Pollard, M.D.

Robert C. Byrd Health Sciences Center of WVU - Morgantown

June 2-3

"The Spiritual Dimension of Illness, Suffering and Dying," (sponsored by the WVU Center for Health Ethics and Law)

West Virginia State Medical Association - Charleston

June 25

Marbury v. Madison, Holiday Inn, Clarksburg

June 28

1994 Medical Billing Seminar, Days Inn, Flatwoods

Outreach Programs

Key to Sponsors

★ *Robert C. Byrd Health Sciences Center of WVU, Morgantown*

☐ *CAMC/Robert C. Byrd Health Sciences Center of WVU, Charleston*

Gassaway ☐ Braxton County Memorial Hospital, June 22, 6:30 p.m., "Diseases of the Larynx," James T. Spencer, M.D.

Oak Hill ☐ Plateau Medical Center, June 28, 6:30 p.m., "Pediatric Trauma," A. Margarita Torres, M.D.

☐ Plateau Medical Center, July 26, 6:30 p.m., "Lumbar," Constantino Y. Amores, M.D.

Logan ☐ Logan General Hospital, July 15, 11:45 a.m., "Trauma Resuscitation: Optimizing in the Golden Hour," CAMC Trauma Services

Madison ☐ Boone Memorial Hospital, June 14, 6:30 p.m., "Common Dermatosis," Donald Farmer, M.D.

☐ Boone Memorial Hospital, July 12, 6:30 p.m., "Chest Trauma," Frank C. Lucente, M.D.

Man ☐ Man Appalachian Regional Hospital, June 15, 6:30 p.m., "Diseases of the Larynx," James T. Spencer, M.D.

☐ Man Appalachian Regional Hospital, July 20, 6:30 p.m., "Medical Evaluation of the Sexually-Abused Child," Kathleen Previll, M.D.

Montgomery ☐ Pleasant Valley Hospital, June 23, noon, "New Technologies in High-Risk Obstetrics," Norman Duerbeck, M.D.

☐ Pleasant Valley Hospital, June 1, 12:30 p.m., "Lower Airway Illness in Infants," Felix R. Shardonosky, M.D.

Point Pleasant ☐ Pleasant Valley Hospital, June 23, noon, "New Technologies in High-Risk Obstetrics," Norman Duerbeck, M.D.

Point Pleasant ☐ Pleasant Valley Hospital, July 28, noon, "Medical Oncology," Steven Jubelirer, M.D.

Richwood ☐ Richwood Area Medical Center, June 9, 5:30 p.m., "Cryosurgical Ablation of the Prostate," James P. Tierney, M.D.

Ripley ☐ Jackson General Hospital, June 10, 12:15 p.m., "Sinus Disease and Surgery," R. Austin Wallace, M.D.

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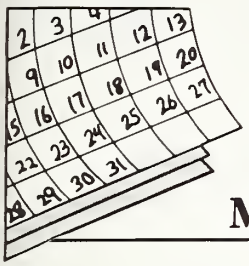


Medical Meetings

June

5-8–41st Annual Meeting of the Society of Nuclear Medicine, Orlando

6-7–Society for Vascular Surgery, Seattle

8-12–International College of Surgeons - United States Section, Chicago

9-11–Southern Association for Geriatric Medicine, Hilton Head, S.C.

10-11–Case Management and Utilization Management in a Changing Healthcare Environment (sponsored by the National Association for Healthcare Quality, Kansas City, Mo.)

10-12–American Congress of Rehabilitation Medicine, Minneapolis, Minn.

16-17–7th Annual Cardiology Symposium: Clinical Cardiology Workshops (sponsored by Ohio State University), Columbus

16-18–Bringing Rural Health and Managed Care Together (sponsored by the National Rural Health Association and the National Center for Managed Health Care Administration), Kansas City, Mo.

18–4th Annual Obstetrics and Gynecology Clinical Update: Urogynecology and Female Pelvic Floor Disorders (sponsored by Ohio State University), Columbus

24-25–Communication Approaches for Tracheostomized and Ventilator Dependent Patients (sponsored by Voicing!, Inc.), Chicago

26–29–American Orthopedic Society for Sports Medicine, Palm Desert, Calif.

26-July 1–7th World Conference on Lung Cancer, Colorado Springs, Colo.

July

7-8–Second International Conference on the Varicella-Zoster Virus (sponsored by the VZV Research Foundation), Paris

8-9–Using Data to Improve Quality in Healthcare (sponsored by the National Association for Healthcare Quality), Houston

11-13–American In Vitro Allergy/ Immunology Society, Cambridge, Mass.

17-18–2nd Annual Alumni Symposium Featuring the William H. Saunders Lectureship (sponsored by Ohio State University), Galloway, Ohio

August

5-6–Quality Improvement in Healthcare: An Introduction (sponsored by the National Association for Healthcare Quality), Chicago

8-10–American Hospital Association, Dallas

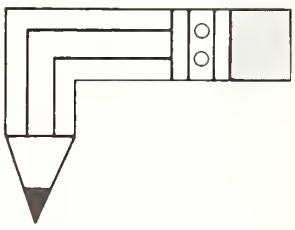
14-17–Midwest Surgical Association, MacKinac Island, Mich.

25-27–Southern Association for Oncology, Sea Island, Ga.

For More Information . . .

Contact the Journal at (304) 925-0342.

Poetry Corner



Ode to the Graduates

For the Medical Class of '94
Congratulations on the score.
Noting you've been tested
As we've suggested.

What was done or said
Was really not so bad.
Hope you forgave us
If we made you mad.

It was lies
When we criticized
Now recalling, youth
Was fine when it was mine!

Medicare and JCAHO
IPA, ISN's, PPA and HMO
For these sets
We send regrets.

Lee L. Neilan, M.D.

Please address your submissions for Poetry Corner to Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

"DO YOU HAVE AN APPOINTMENT ?"

Department of Health & Human Resources

Bureau of Public Health News

This page of material is submitted and paid for by the Bureau of Public Health.

Risk factor study looks at health habits of West Virginians

A survey of state adults shows West Virginia has the nation's lowest prevalence of heavy alcohol drinking, but the second highest incidence of obesity. Information about these and other health factors are included in the *1992 Behavioral Risk Factor Survey*, recently released by the Bureau of Public Health's Office of Epidemiology and Health Promotion.

This annual report presents data on behaviors that can put people at risk of preventable illness and death. These factors include not using seatbelts, hypertension, obesity, sedentary lifestyle, cigarette and smokeless tobacco use, and alcohol misuse.

More than 34% of adults in the state reported being at least 20% over their ideal weight, with only Mississippi reporting a higher rate. Nearly 19% of the men surveyed used smokeless tobacco, and West Virginia ranked first among the 13 states that rated its prevalence. The data also showed 66% of the state's adults aren't physically active, 40% don't use their seatbelts regularly, and that 24% had high blood pressure.

The state, though, is making headway in reducing unhealthy habits. While it does have a high smoking rate of 24%, the prevalence of smoking has fallen steadily over the nine years this survey has been conducted. According to questions about alcohol use during the month previous to the interview, 2% reported having had 60 or more drinks, 9% reported having had five or more drinks on at least one occasion, and 1% reported drinking and driving.

Survey results will be used to help establish health policies and to monitor the disease prevention efforts. For more details or to obtain a copy of the report, phone the Bureau's Health Statistics Center at (304) 558-9100.

State's breast, cervical cancer rates increasing

The number of breast and cervical cancer cases among West Virginia women increased between 1991 and 1992, according to a report released by the Bureau of Public Health. *The West Virginia Breast and Cervical Cancer Incidence and Mortality Report for 1991-1992* examines the occurrence, death rates and state of diagnosis of breast and cervical cancer cases in the state. This is only the second year such data has been available.

For each 100,000 West Virginia women, 90.1 were diagnosed with invasive breast cancer in 1992, up from 86.8 in 1991. The invasive cervical cancer rate increased from 10.8 to 12.9 during the same time period. These age-adjusted incidence rates are based on data collected from hospitals, laboratories, physicians, clinics, the Bureau's Vital Registration Office and its Breast and Cervical Cancer Screening Program, and from the cancer registries in other states.

The age-adjusted death rate for cervical cancer rose from 3.6 cases per 100,000 women in 1991, to 3.8 in 1992. The latest available national data shows West Virginia had the fifth worst death rate from cervical cancer in the United States from 1986 through 1990. However, the age-adjusted death rate for breast cancer fell to 24.7 per 100,000 women in 1992, down slightly from 25.5 in 1991.

The report also showed early diagnosis of breast and cervical cancer rose in 1992 in many geographic areas of the state. Early diagnosis of breast and cervical cancer is extremely important because these diseases can be treated more easily and five-year survival rates are greater.

This annual data collected by the Bureau's Cancer Registry will help determine the best use of resources for prevention and early detection of breast and cervical cancer. The information will also identify any geographic areas where there is an unusual occurrence of cancer.

To learn more about the report or the Cancer Registry, contact Beverly Keener at (304) 558-5358 or 1-800-423-1271.

Adolescent health topic of new report

During a typical month in West Virginia, seven adolescents will die as a result of a preventable injury, 112 babies will be born to teens, 670 young people will start smoking, 341 teenagers will drop out of school and 84,000 of the state's youth will go without proper health care.

These are just a few of the statistics that are contained in a a new report, *The Adolescent Health Profile*, released by the West Virginia Bureau of Public Health's Office of Maternal and Child Health (OMCH). This report was compiled by staff from the OMCH's Adolescent Health Initiative, a new program developed to improve the health of West Virginians between the ages of 10 and 17 years old. Since most adolescent health problems result from risk-taking behaviors, the program promotes preventive health education, especially on the community level.

Divided into 12 sections, this report reveals statistics on areas such as disease, reproduction, nutrition and fitness, education and employment, mental health, and health care finances. Some of the findings are as follows:

*The state's rate of teen suicides is 16% lower than national rate.

*The state's rate of teen homicides is 34% lower than the U.S. rate.

*Automobile accidents account for 73% of all unintentional injury deaths to adolescents in the state.

*Chronic or congenital illnesses account for nearly 25% of all deaths to the state's youth.

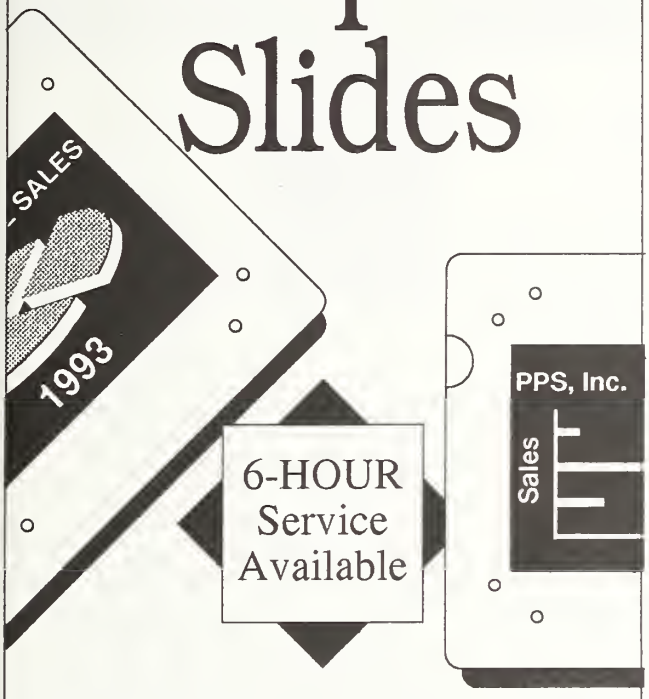
*More than 25% of all state high school students are overweight or obese, and only about half of them regularly exercise.

*In 1992, more than 139,000 West Virginians under the age of 21 were eligible for Medicaid.

*From 1984-93, 20% of the state's AIDS cases were people between the ages of 20-29 who were probably infected as teens.

For a copy of the report, call Nelson Parker at (304) 558-3071.

Text & Graphic Slides



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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

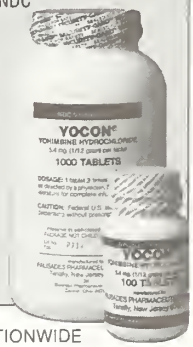
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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ROBERT C. BYRD HEALTH SCIENCES CENTER
OF WEST VIRGINIA UNIVERSITY

Compiled from material furnished by the Robert C. Byrd Health Sciences Center of West Virginia University, Communications Division, Morgantown

Lasers being utilized to remove tattoos, birthmarks, liver spots

Jacobsen

Tattoos, brown aging spots, freckles and red or brown birthmarks can now usually be safely and painlessly removed using new laser technology available at WVU.

"Up until now there has been no good method to remove these," Dr. Ellen Jacobsen, adjunct assistant professor of dermatology said. "Argon lasers that were introduced for this purpose several years ago often had unsatisfactory results. The treatment was painful, and often the tattoo or birthmark was replaced by a scar.

"That's no longer the case. In the last decade, there have been significant advances in the technology available to remove unwanted pigment from human skin. It's very exciting to have these new lasers that can erase most tattoos, port wine stains, liver spots and superficial red blood vessels painlessly, and without any lasting scars," Dr. Jacobsen added.

The lasers can be used safely on the face -- even around the eyes. It also works very well on spidery red blood vessels on the face.

New library dedicated for Biochemistry

The Department of Biochemistry recently dedicated the George H. Wirtz Memorial Library, which was created within the department in order to keep faculty and students abreast of the latest developments in the field.

George Wirtz, Ph.D., who died last year, was a professor in the Department of Biochemistry for 30 years.

Article written by Antonelli published in *Academic Medicine*

Antonelli

The March issue of *Academic Medine* features an article entitled "*Practicing Physical Evaluation Skills on Community Volunteers*," by Dr. Mary Ann Antonelli, associate professor of rheumatology. Dr. Antonelli's article describes the reaction of community volunteers who were the subjects in a physical diagnosis preceptorship.

Ferrari, Moore elected to national task forces

Dr. Norman D. Ferrari, pediatric clerkship director, and Dr. Renee Moore, assistant pediatric clerkship director, have been chosen to serve on task forces for the national organization of pediatric clerkship directors.

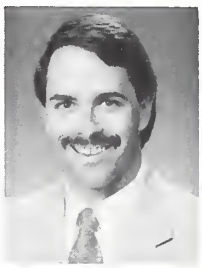
Dr. Ferrari will be serving on the evaluation task force and chair the subcommittee on grading policy, and Dr. Moore will be a member of the faculty development task force. Their appointments were made at the recent meeting of the Council on Medical Student Education and Pediatrics in San Antonio, Texas.

Hornsby named ADA board member

W. Guyton Hornsby Jr., Ph.D., C.D.E., assistant professor of exercise physiology, has been nominated for a three-year term on the American Diabetes Association Board of Directors.

In association with the ADA, Dr. Hornsby has published "*The Fitness Book - For People with Diabetes.*" Dr. Irma Ullrich, professor of endocrinology/metabolism, was a contributing editor.

Post presents lectures, authors chapter


Post

Dr. William R. Post, assistant professor of orthopedics, served as a faculty member at the American Academy of Orthopedic Surgeons Winter Sports Medicine Course in Steamboat Springs, Colo.

At the meeting, Dr. Post presented lectures on arthroscopic knee meniscus repair, diagnosis and treatment of patellofemoral pain and instability, arthroscopic repair for recurrent shoulder dislocations, and new concepts in tennis racket design and their implications for players of all levels.

In addition, Dr. Post recently published a chapter on surgical treatment of patellofemoral disorders that appeared in a two-volume textbook entitled "*The Knee.*" (Mosby Co. 1994).

Gruen lectures at orthopedics workshop

Thomas A. Gruen, M.S., adjunct associate professor of orthopedics, was a presenter at the "Contemporary Topics in Orthopaedics" conference in Sugarloaf, Maine from March 11-13.

Guen discussed radiographic assessessment of osteolysis versus stress-shielding with total hip femoral components, and problems associated with quantitative radiography in orthopedics.

Landreth receives Benedum award

Kenneth Landreth, Ph.D., professor of microbiology/immunology, is one of the four recipients of WVU's 1994 Benedum Distinguished Scholar Award.

Dr. Landreth's Benedum lecture was entitled "*Bone Marrow Lymphocyte Production.*"

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Marshall University School of Medicine

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington

Hanshaw Center to expand into major geriatric institute

The Huntington Foundation has pledged nearly $1 million to expand Marshall's Frank E. Hanshaw Sr. Geriatric Center into a comprehensive Geriatric Medicine Institute.

In announcing the 7-year, $932,800 grant, MU President J. Wade Gilley said the Huntington Foundation now has donated more than $2.4 million to Marshall.

"In 1988, the Huntington Foundation made a visionary decision to grant $1 million to Marshall's School of Medicine to establish the Frank E. Hanshaw Sr. Geriatric Center," Gilley said. "Since that time, the Hanshaw Center has become a vital link in providing services to the elderly. In addition to providing geriatric medical care, the center is at the forefront of geriatric education and service coordination for all of West Virginia and the mid-Ohio Valley."

Hanshaw will continue to focus chiefly on comprehensive evaluation services, although some patients still will use the center as a source of primary care, according to Dr. Shirley Neitch of the School of Medicine who will direct the center. Dr. Neitch said the grant will enable the center to expand its home-visit program and its geropsychology, social work and rehabilitation services, as well as provide for prompt assessment of patients referred by human service agencies for urgent placement or possible abuse situtations.

"An important component of our plan to expand to a Geriatric Medicine Institute is that we will begin to do health services delivery research aimed at developing ways to 'export' the comprehensive assessment process to outlying primary care practice sites," Dr. Neitch said. "What we do in Huntington could be done by front-line care providers if certain modifications and educational efforts could be initiated. Such a program would require additional funding from other resources, but would not be possible at all without the Hanshaw Center as a base," she elaborated.

Demand also is expected to increase for the services of Kathryn Riley, M.D., West Virginia's only geropsychologist. Dr. Riley conducts comprehensive, individually-tailored neuropsychological test batteries upon patients to determine whether their cognitive abilities are impaired due to a dementing disease such as Alzheimer's, or a "pseudo-dementia" caused by depression or anxiety. As the center's reputation has grown, an increasing number of patients have been referred to Dr. Riley for evaluation and treatment of psychological disorders such as depression, anxiety, grief reactions, adjustment disorders, and the psychoses.

The Geriatric Medicine Institute will provide increased opportunities for medical students, residents and fellows. Marshall is intensely involved with the state's other medical schools to obtain a federal grant to establish a Geriatric Education Center for West Virginia, Dr. Neitch said. "This will primarily be a faculty education grant which, through interface with the Kellogg and Rural Health Initiative training sites, will provide solid geriatric education for a multitude of care providers.

"As we head into the 21st century, we anticipate continuing growth of the elderly population, with many experts estimating that fully 20 percent of the population will be over 65 years old. The Huntington Foundation grant will allow us to address the escalating need for geriatric care and education," Dr. Neitch added.

MU again earns AAFP's Silver Award

On May 2, Marshall again received the Silver Achievement Award of the American Academy of Family Physicians for being one of the top three U.S. medical schools in the percentage of graduates entering family practice residency programs.

The AAFP initiated the Family Practice Percentage Award program two years ago to honor LCME-accredited medical schools that have a high percentage of graduates who enter ACGME-accredited family practice residency programs over the preceding three-year period.

For the 1991-1993 period, Marshall had 27.7 percent of its graduates entering family practice residencies, a percentage topped only by Mercer University School of Medicine and the University of North Dakota School of Medicine. Twelve medical schools received bronze awards for averages between 20 percent and 24.9 percent.

Nine grads honored at commencement

Nine graduating medical students received the following awards during commencement activities for the School of Medicine:

Dr. Caroline B. Miller - The Bertha and Lake Polan Award for the student with the highest academic standing, and also the Upjohn Achievement Award for being the graduate who faculty members believe represents the highest attributes of physicianhood.

Dr. Cris R. Richardson - The CIBA-Geigy Award for the graduate who, in the opinion of his peers, exemplifies the ideal physician.

Dr. Robert A. Barnabei - The Bettye and Albert Esposito Award (community service).

Dr. Michael L. Meadows - The W. Edwin Black Award (family practice).

Dr. Michael J. Maroney - The Fuller Albright Award (endocrinology).

Drs. G. Marshall Lyon III and **Bradley J. Richardson** - The Cardiology Award.

Dr. Patricia J. Wilson - The Gastroenterology Award.

Dr. Kimberly A. Oxley - The Thomas G. Folsom Award (pediatrics).

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We are more than "just" medical students

Dear Fellow Medical Students:

Let me start by reminding everyone that the WVSMA Medical Student Section offers us the perfect opportunity to become a visible and active influence in the future of health care. Since we will be practicing physicians within the next few years, our suggestions for improving health care both at the state and national level system are vital.

Thanks to the work of previous Executive Council members, the WVSMA-MSS has a solid foundation and now it is up to us to help continue their outstanding efforts. I hope the MSS will grow even stronger this year through increased membership and expanded programs, and I want all members to feel they have an equal opportunity to take part in our organization.

At this time, I want to list all of this year's officers and encourage you to contact me or any of the other officers to express your opinions and ideas:

	Executive Council	Huntington	Morgantown
President	Dave Faber	Mary Marcuzzi	Linda Burstynowicz
Vice President	Nick Cottrell	Teresa Duncan	Missy Matulis
Secretary/Treasurer	Lisa McAvey	Tony Aprea	Kristin DeHaven

*The Charleston Division of WVU officers will be determined in July.

Information is the name of the game, and our organization offers many ways of obtaining this knowledge. Find out all you can about health care and the issues surrounding it by attending state and national conferences, becoming involved with your communities, and interacting with political leaders. I would also like to see each of the component societies increase their participation. This is the one of the most effective ways of keeping everyone informed about current issues that may affect us as individuals and our future as a whole.

At our Executive Council meeting in April, we were able to plan our agenda for this year. One of the most important decisions we made was to create an indepth survey that would be sent to all medical students. Once the results are tabulated, we plan to publish them in the *Journal* and present them to members of the West Virginia Legislature.

In closing, I would like to extend my sincere thanks to each of you for allowing me to represent you as the president of the Executive Council of the WVSMA-MSS and ask you to always remember this thought: We are more than "just" medical students, we are future physicians, we are in the system, and we have a voice.

David C. Faber, MS III
WVSMA-MSS President

P.S. PLEASE MARK YOUR CALENDARS NOW AND PLAN TO ATTEND OUR NEXT COUNCIL MEETING ON JULY 23 AT THE WVSMA OFFICE IN CHARLESTON!!!

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Obituaries

Carl E. Johnson, M.D.

Dr. Carl E. Johnson, 93, of Charlotte, N.C., formerly of Morgantown, died March 20 at Presbyterian Hospital in Charlotte.

Dr. Johnson was born in Davis, and after graduating from high school in 1918, he was in the student army training corps at Washington and Lee University. He then attended WVU, where he received a bachelor of arts degree in 1924 and a bachelor of science degree in 1925. He obtained his medical degree from Northwestern University Medical School.

Following his internship at Harper Hospital in Detroit, Dr. Johnson opened his office in 1928 at the Monongahela Building in Morgantown, the address which he kept for the duration of his 46-year practice. A respected member of Morgantown's medical community, Dr. Johnson was known for his 24-hour-a-day commitment to his patients. He was a family practice physician who specialized in pediatrics, and during the early part of his career he delivered babies. Often he was paid for his services with produce, chickens or other forms of barter.

Dr. Johnson administered the first polio vaccine in Monongalia County on April 18, 1955; and until he retired from practicing in 1974, he made house calls.

"House calls are valuable tools in treating patients," Dr. Johnson had once said. "I'd have the opportunity to see from the homes if the patients were happy, getting along all right, or possibly having a hard time economically, all factors which affect recovery."

During his career, Dr. Johnson was chief of staff at Monongalia General Hospital and St. Vincents Pallotti Hospital. He was also a clinical associate professor at WVU and was on the staff of the WVU Medical Center Hospital. In addition, Dr. Johnson was a medical advisor for Head Start of Monongalia County and for Selective Service Local Board 14, as well as a medical examiner for C & P Telephone Company.

Dr. Johnson was president of the Monongalia County Medical Society in 1942 and served as secretary from 1940-42. A member of the WVSMA Council for nine years, Dr. Johnson also served on several WVSMA committees. A fellow of the American College of Physicians since 1943, Dr. Johnson was also a member of the AMA, West Virginia Pediatric Society, and the boards of the Morgantown Hospital Association, Medical Surgical Services and Valley Counseling Services.

After he retired in 1974, Dr. Johnson became president of the Monongalia General Hospital Foundation from 1976-1986. At a 1992 Monongalia General Hospital and Morgantown Orthopedic Associates' tribute, Tom Senker, president and CEO of Monongalia General, described Dr. Johnson as "the epitome of a scholar, a professional and a gentleman."

Dr. Johnson is survived by his wife of 67 years, Lillian Posten Johnson; one son, Carl Edward Johnson Jr. of Charlotte; one daughter, Mrs. Jennifer Johnson Firestone of East Bernard, Vt.; and four grandchildren.

Donations can be made to the Foundation of Monongalia General Hospital Inc., 1200 J. D. Anderson Drive, Morgantown, WV 26505.

John H. Kilmer, M.D.

Dr. John Henry Kilmer, 84, of Martinsburg, died February 10.

Dr. Kilmer was a graduate of Martinsburg High School, West Virginia University, and Thomas Jefferson Medical College in Philadelphia. He served his internship at the Ohio Valley General Hospital in Wheeling, and the Lutheran Hospital in Fort Wayne, Ind. He completed his residency at Columbia Hospital for Women in Washington, D.C.

Dr. Kilmer was a well-known obstetrician and gynecologist in Martinsburg for over 35 years, who retired from private practice in 1976. During his career, he also served as plant physician for E.I. DuPont and Corning Glass Works; as physician for Norborne Nursing Home; and as the coroner for Berkeley County.

Actively involved in community affairs, Dr. Kilmer served as president of the Berkeley County PTA, the Eastern Panhandle West Virginia University Alumni Association and St. John's Lutheran Church Council. He also was instrumental in the establishment of the Panhandle Home Health Association.

Dr. Kilmer was a retired colonel from the U.S. Army Reserve. He served on active duty in the European Theater with the U.S. Medical Corp during World War II, receiving the Silver Star, the Bronze Star, two Purple Hearts, the Combat Infantryman's Badge, three Arrow Heads and the African Campaign Ribbon with seven stars.

Dr. Kilmer was a fellow of the American College of Obstetricians and Gynecologists. In addition to being a member of the WVSMA, he was a member of the AMA, the Eastern Panhandle Medical Association, Phi Kappa Psi fraternity, and St. John's Lutheran Church, Martinsburg.

Survivors include two sisters, Eva Lee Plunkett and Katherine Bush, both of San Antonio, Texas; two sons, John H. Kilmer Jr. and Wade C. Kilmer, both of Martinsburg; four daughters, Judith K. Kilmer of Martinsburg, Patricia G. Anderson of Tucson, Ariz., Fredrica H. Meitzen and Katherine K. Powell, both of Morgantown; two grandsons, Derek L. Kilmer and Jacob P. Powell; two granddaughters, Heather K. Kilmer and Tecca R. Kilmer; and several nieces and nephews. He was preceded in death by his wife, Dorothy Dammeier Kilmer.

Memorial contributions can be made to St. John's Lutheran Church, Queen Street, Martinsburg.

Society News

McDowell

The members began their March meeting will a special expression of appreciation to Dr. Charles Michaelis for all of his outstanding work as secretary-treasurer over the past few years.

Dr. Herland shared a letter from the Welch Chamber of Commerce requesting funds for Project Graduation. The members then voted to make a donation to the three county high schools, as the society had done in previous years.

In other new business, Dr. Herland urged all members to support the WVSMA with their dues and contributions. At his suggestion, the members also approved sending a letter to the Tug River Health Association, congratulating them on the formal dedication of their new satellite clinic in Northfork. In addition, Dr. Michaelis announced that a notice had been put in the local newspaper about the society's new Speakers Bureau.

West Virginia Medical JOURNAL

June 1994 West Virginia State Medical Association Volume 90 No. 6

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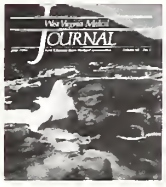

Front Cover

The beautiful Sandstone Falls area of the New River National Park in Summers County. Photo courtesy of *Stephen J. Shaluta Jr.*, West Virginia Division of Tourism and Parks.

Knowledge of medical charges

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Abstract

Ignorance of medical charges by decision-makers could handicap cost control programs. By written survey, we determined the ability and confidence of 267 adults, including 85 health care workers, to estimate four medical charges: epidural anesthesia for childbirth, outpatient hernia surgery, dipyridamole-thallium heart stress test, and a one month supply of nicotine drug patches. Only 36% of the estimated charges fell within 50% of the actual charges for the four medical services. Accuracy did not differ among physicians, non-physician healthcare workers and consumers; estimates varied greatly with many being extremely low or high. Respondents rated medical charges significantly more difficult to estimate than non-medical. Seventy percent of respondents felt that most physicians do not know enough about medical charges to give good advice and 92% felt that they did not know enough about medical charges to make satisfactory choices.

Introduction

Consumers and providers generally agree that health care is expensive and requires reform. Cost control proposals include elements of rationing, competition, allocation of global budgets, group alliances and improved practice efficiency. All these proposals depend on decision-makers having sufficient knowledge of medical costs to make rational economic decisions, and past studies (1,2) and current reports (3,6) reveal ignorance of medical charges.

To further understand the current limits of medical charge knowledge, we surveyed 267 consumers and providers in the Morgantown health care market.

Methods

To conduct our research we tested two hypotheses:

1. Most people can estimate charges for medical services and goods within 50% of their actual values; and
2. No difference exists between perceived difficulty of estimating medical and non-medical charges.

We surveyed a stratified sample of adults with a written questionnaire with the following four sections:

(1) Knowledge of medical charges;
(2) Knowledge of non-medical charges;
(3) Opinions; and
(4) Personal data.

The first section asked respondents to estimate the charges for each of the four following medical services or goods at West Virginia University Hospital:

(1) Epidural anesthesia for childbirth (anesthesiologist, supply and drug charges);
(2) Surgery as an outpatient for hernia repair without complications (surgeon, anesthesia and hospital charges);
(3) Heart stress test as an outpatient using dipyridamole-thallium; and (hospital and doctor charges); and
(4) A one-month supply of nicotine patches (drug only).

These services and goods were described to identify all components of the final charge, and the last question in this section asked the respondent to rate on a scale of 1 to 10 the ease (1) or difficulty (10) of estimating these four medical charges.

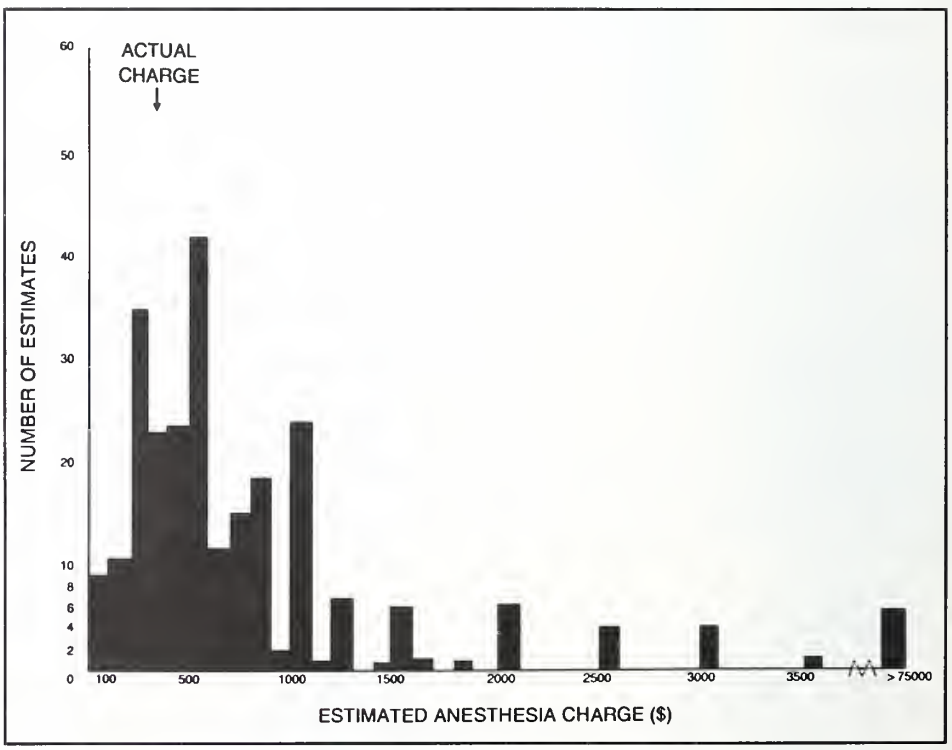

Figure 1a. Distribution of charge estimates for:

A. Epidural anethesia for childbirth
B. Outpatient hernia surgery
C. Dipryridamole-thallium heart stress test
D. A one-month supply of nicotine drug patches

The second section of the survey asked respondents to estimate charges associated with the following four non-medical services:

(1) Minimum in-state tuition for a full-time undergraduate engineering student for one semester;

(2) Usual fees of a local certified public accountant to prepare a 1040 form without additional schedules;

(3) Usual fees for a local lawyer to prepare a simple will without trust forms; and

(4) The monthly charge for local basic cable television service.

As in the first section, the final question asked the respondent to rate the ease (1) or difficulty (10) of estimating these four non-medical fees.

The third section asked if the respondent thought that most physicians knew enough about medical charges to give good advice to patients, and if the respondent knew enough about medical charges to make satisfactory choices. The last section requested the individual to give his/her age, occupation and highest education level completed.

Implementation and analysis

Attendees at a medical grand rounds, anesthesia grand rounds, bioethics conference, undergraduate business lecture, elementary school teachers conference and civic club meeting, as well as shoppers at a local mall, were asked to complete the survey. General information, but no price clues, were provided concerning the survey.

Respondents had unlimited time to complete the survey and could skip questions they were unable or unwilling to answer. Mall shoppers completing the survey received a university pen and pencil. Actual medical values were determined by interviewing the clerks who enter medical charges into the computerized billing systems for the hospital and medical practice, and they were then confirmed by directors of the various departments. Actual bills from 10 patients undergoing dipyridamole-thallium heart stress tests were randomly selected on 10 different days to validate reported charges. Non-medical values were determined by a telephone survey of local lawyers and accountants, and by contacting appropriate officials at WVU and cable television offices. Estimates by respondents were analyzed and reported with descriptive statistics.

The hypothesis concerning accuracy of charge estimation would be rejected if less than 50% of the responses fell within 50% of the actual charges. Rejection of the hypothesis concerning perceived difficulty of estimating medical versus non-medical charges

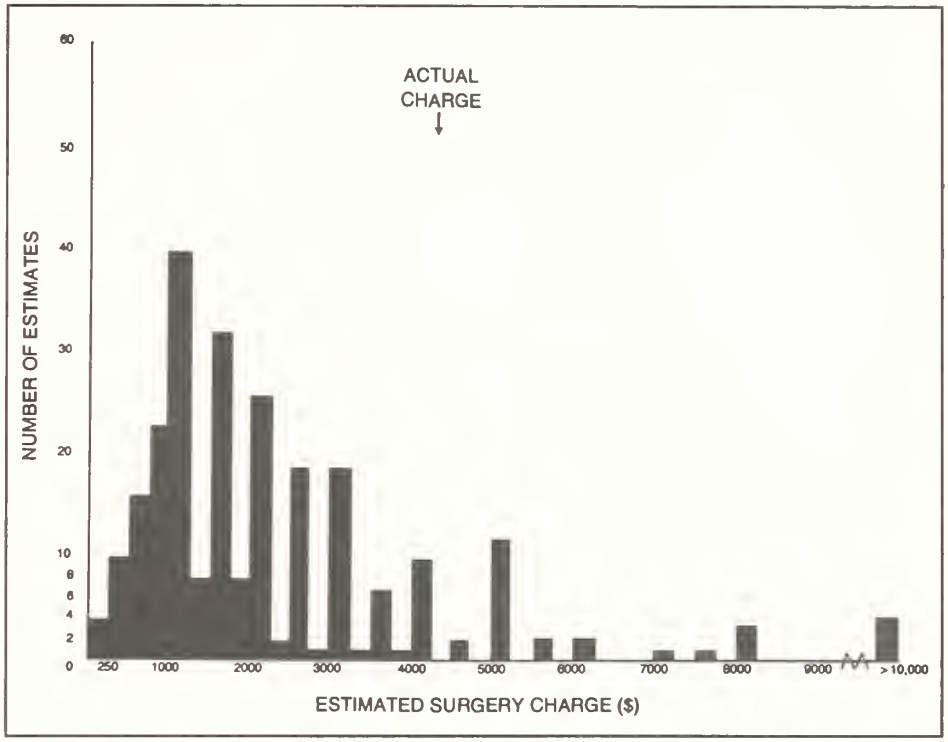

Figure 1b.

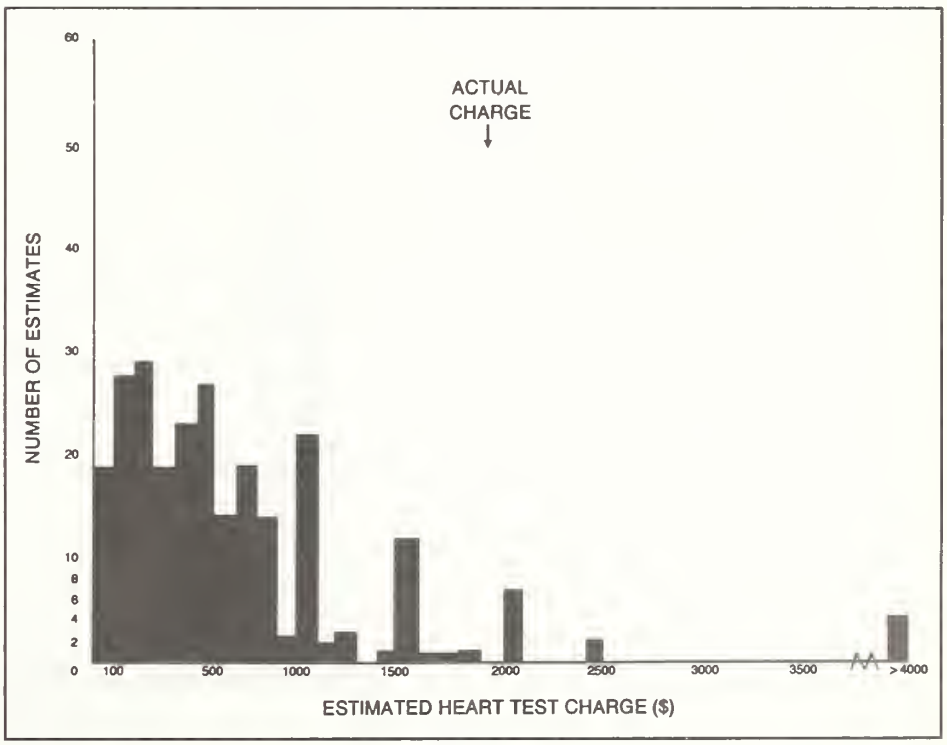

Figure 1c.

was determined by a significant difference between the Likert scale rankings using the Mantel-Haenszel chi-square test.

Results

The total number of surveys returned with answers was 267. Approximately 15 people read the survey and declined to provide any answers, usually saying it was "too difficult." Thirty-two percent of the respondents worked or studied in the health care field and seven percent did not list their occupation. Those respondents who were in a health-related field included physicians, medical technicians, nurses, medical students, administrators, and ancillary hospital staff.

The ages of all respondents ranged from 18 to 79, with 83% falling between 18 and 45. In addition, 13% of those answering the questionnaire had not gone to college, 57% were college graduates, 11% had master's degrees, 4% had doctorate degrees, and 15% had medical degrees.

Actual charges

The actual total charge for a dipyridamole-thallium cardiac stress test, $1,977, was determined by adding seven separate charges together. These charges included $78 for thallium, $365 for dipyridamole, $714 for imaging, $125 for the radiologist, $133 for the cardiologist, $493 for the stress lab, and $69 for computer usage.

Examination of the 10 patients receiving dipyridamole-thallium heart tests showed only six had received all seven charges. Three patients were missing charges for dipyridamole, one for the radiologist, and one for the stress lab. Two patients had additional charges which apparently originated during the stress testing; one for consultation and one for an electrocardiogram. Excluding the additional charges, the average amount actually charged patients was $1,783. No clerk, technician or physician interviewed during this process correctly stated all seven charges consistently.

Analyses

Estimated charges varied greatly, and the mean responses and actual values for each charge estimated are given in Table 1. The mean estimates exceeded the actual values for the epidural anesthesia and the nicotine drug patches by 131% and 35%, but fell below the actual values for the hernia surgery and the dipyridamole-thallium heart stress test by 49% and 61%.

Health care workers and physicians were not more successful than non-health care respondents in estimating charges. Figure 1 shows bar graphs of the distributions of charge estimates for the four medical procedures. The percentages of responses falling within 50% of the actual values are shown in Table 2. Overall, only 38% of medical charge estimates were within 50% of actual values, which proved our first hypothesis was incorrect.

Examination of charge estimates using different criteria for accuracy or outliers consistently showed a great variation of estimates, and that respondents could not estimate the medical charges as well as the non-medical. For instance, only 18% of respondents overall estimated the medical charges within ± 20%, whereas 32% estimated non-medical charges within this range.

Opinions

On a scale of 1-10, respondents rated medical charges significantly more difficult to estimate than non-medical charges (8.1 ± 2.0 versus 5.7 ± 2.1, $p < 0.05$). Seventy percent of respondents, including all physician respondents, felt that most physicians do not know enough about medical charges to give good advice to patients.

Ninety-two percent of respondents felt that they did not know enough about medical charges to make satisfactory choices. No differences among respondents by age or educational level were detected.

Discussion

Since health care is so expensive and its costs are increasing so fast, system reform is often justified on this basis alone. Many proposals exist and they all address costs through many different mechanisms (7). One proposal advocates "savings from small-market reforms" (8), and President Clinton has advocated "a restructured set of ground rules that foster competition to provide the best care at the best price" (9).

Both of these strategies, as well as most other cost-control proposals, depend on the knowledge of charges by decision-makers. If the decision-maker is the patient, then success depends on his or her ability to shop for the best deal. If the decision-maker is the physician or another health care agent, then this advisor must select effective products and services from treatment options with varying costs. For either process to

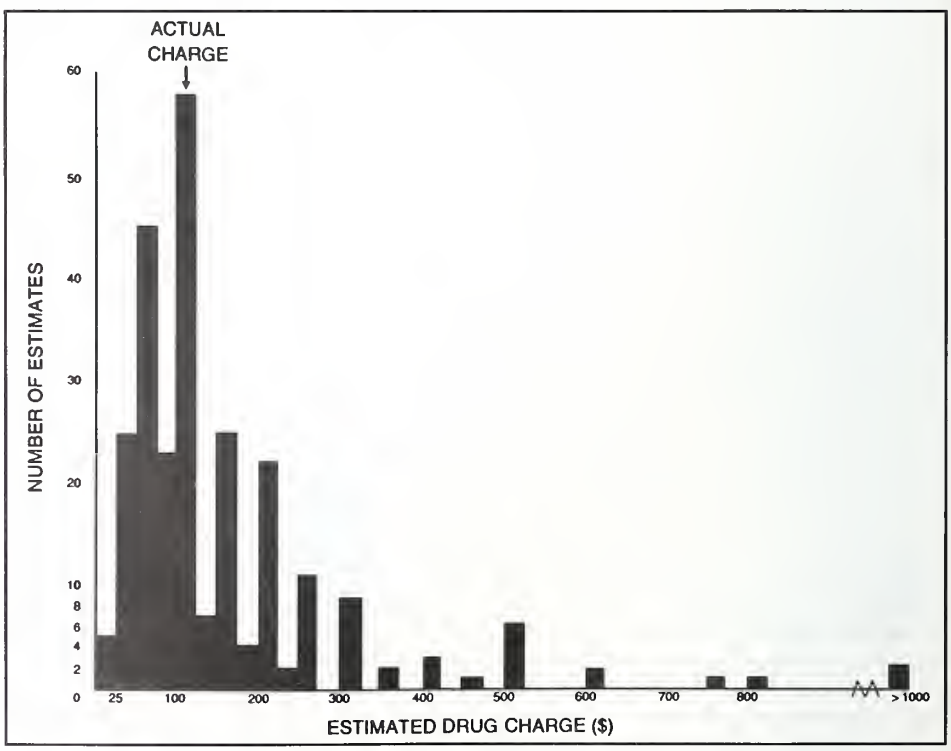

Figure 1d.

succeed, the decision-maker must know the costs of, as well as have access to, all the medical goods and services under consideration.

This study found that a diverse group of West Virginia physicians, health care workers, and consumers could not estimate locally prevailing medical charges. Many were uncomfortable even trying. No individual respondent came within 50% of the actual value on all four medical charge questions, and many respondents gave estimates far removed from the actual values. Health care purchasers who estimate too low may feel cheated when discovering the actual charge, and consumers who estimate too high may not pursue needed medical services, or may pay too much for what they obtain. The frustration of many respondents estimating charges was epitomized by one who left some answers blank and said "I just don't have a clue." It is also surprising that not one of 40 physicians, after trying to estimate the four medical charges, thought that physicians knew enough about charges to give good advice.

This study has many limitations since the survey involved only one locality, did not cover all medical goods and services, and the respondents did not represent all demographic groups. Costs at a university hospital are higher than at many community hospitals, and the surveyed Morgantown residents may have a different awareness of prices than in other communities. This study also does not show that ignorance of medical prices is damaging or causes cost control programs to fail. Perhaps the respondents, in real-life situations, could find the necessary price information since some insurance companies and consulting groups are now building financial databases and selling this information. Prices may not even be important in a system where insurance companies or large payers have enough clout to decide what is paid. However, the ignorance of prices and frustration were so profound that they appear to be real problems.

Another limitation of this study is the fact that it does not determine the reasons why people have so little knowledge of medical prices. One reason could be that the general public has difficulty understanding medical terms, so weighing medical treatments, even without considering cost, is confusing. Physicians may require specialty consultations to differentiate technical procedures. Once the medical procedures are understood, there is frequently confusion over whether hospital costs or patient charges are more pertinent, and over which goods and services are charged together. What is a comprehensive charge in one hospital may be broken apart or grouped differently in another hospital. There are few national standards for charging and each locality develops their own systems.

Bundling or separating charges are each justifiable and promote different kinds of fairness, but the diversity makes acquiring price knowledge difficult. Consent forms which describe medical procedures and risks in detail seldom include costs, so neither physicians nor patients learn or consider this economic fact. In addition, more than one legal (billing) entity may deliver one apparent service. As found in this study, several physicians and hospital departments, each presenting separate bills, were involved with one dipyridamole-thallium stress test, and the different departments were not sure what the others charged.

It is obvious that the system of identifying, entering and accumulating medical charge data and presenting medical bills is so intricate that errors occur and charges can vary among patients for the same treatment. Thus, it can be extremely difficult to determine total charges for a specific treatment, and even a sophisticated hospital has difficulty billing them consistently.

Who should bear the responsibility for health care cost containment -- consumers, providers, payers or regulators? A global determination that neither medical nor non-medical populations could estimate medical charges accurately would be alarming and might drive cost-containment efforts in a direction that neither physicians nor patients desire. Until the extent and meaning of price ignorance are known or other answers to expensive health care are found, cost simplification and education deserve emphasis, and by themselves could constitute reform.

Table 1. Characteristics of Medical and Non-Medical Charge Estimates

Service	N	Mean + SD	Min	Max	Actual
Anesthesia	253	$793 ± 1,037	$20	$10,000	$344
Surgery	254	$2,218 ± 1,940	$150	$15,000	$4,323
Heart test	251	$767 ± 1,639	$15	$20,000	$1,977
Drug	254	$149 ± 160	$20	$1,500	$110
Tuition	259	$1,748 ± 1,488	$450	$10,000	$1,049
Tax	259	$134 ± 118	$15	$700	$75
Will	258	$209 ± 180	$10	$1,150	$75
TV	262	$26 ± 9	$10	$100	$22

Table 2. Percentages of Charge Estimates Falling Within 50% of the Actual Charge

Service	Within 50%
Anesthesia	48
Surgery	24
Heart test	24
Drug	51
Medical Average	38
Tuition	65
Tax	50
Will	36
TV	83
Non-Medical Average	59

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Differential diagnosis of wide QRS tachycardias

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Abstract

This article reviews new criteria for distinguishing ventricular tachycardia from supraventricular tachycardia with aberrancy.

Introduction

A rapid arrhythmia with wide QRS complexes is either ventricular tachycardia or supraventricular tachycardia with aberrant ventricular conduction. It can be difficult to distinguish between these possibilities, but proper therapy hinges on a correct diagnosis.

Older criteria for differentiating between these two conditions included complex morphologic features, which were difficult to apply and often not reliable (1). Recently, a simplified stepwise approach has been advocated (2), and this article reviews our experiences with two cases in which we utilized this new approach.

First case report

A 64-year-old woman presented with palpitations and chest pain. She had an old anteroapical myocardial infarction, and past cardiac catheterization showed an occluded left anterior descending artery. The ejection fraction was 24%. She did not appear to be distressed.

This patient's pulse was 150 beats/minute and the blood pressure 125/70 mmHg. After an EKG (Figure 1), she was given procainamide I.V., which slowed the rate to 129 beats/minute, but did not affect the QRS morphology. The mechanism of the tachycardia remained unclear, and an echocardiogram was performed, which was interpreted as showing 1:1 association between atrial and ventricular contraction. Based on this observation and the absence of hemodynamic instability, a diagnosis was made of supraventricular tachycardia with aberrant ventricular conduction.

Later, this patient was electrically cardioverted and underwent electrophysiologic (EP) testing. This reproduced her arrhythmia and confirmed the mechanism as ventricular tachycardia. She was successfully treated with intraoperative mapping and resection of her arrhythmia focus.

Second case report

A 58-year-old man presented with palpitations and near syncope. He was confused and had a systolic blood pressure of 70 mmHg. His EKG is shown in Figure 2, and physicians thought he was in sustained ventricular tachycardia, so he was electrically cardioverted to normal sinus rhythm.

Subsequent work-up revealed a normal echocardiogram, normal treadmill exercise test with thallium imaging, and the presence of dual atrioventricular (AV) nodal pathways (3) at EP study. During this study, this patient was also inducible into sustained AV nodal reentrant tachycardia, which was accompanied by aberrant ventricular conduction having a left bundle branch morphology. His EKG during this arrhythmia was identical to the one that had been obtained when he first came to the emergency room. He elected to try medical therapy before catheter ablation, and has done well on verapamil 240 mg/day.

Misconceptions

Several misconceptions about wide QRS tachycardias appear to be rather commonly held in the medical community (Table 1). Of these, probably the most prevalent is that a hemodynamically stable patient with a good blood pressure cannot be in ventricular tachycardia. This is a false assumption, which can lead to prolonged delays in appropriate therapy.

In our experience, it is not rare to see patients with monomorphic ventricular tachycardia who tolerate their arrhythmia well for hours or even days and have only mild symptoms. Conversely, it is not rare for supraventricular tachycardias to present with hypotension, as illustrated

FIGURE 1. The EKG of the patient in Case 1.

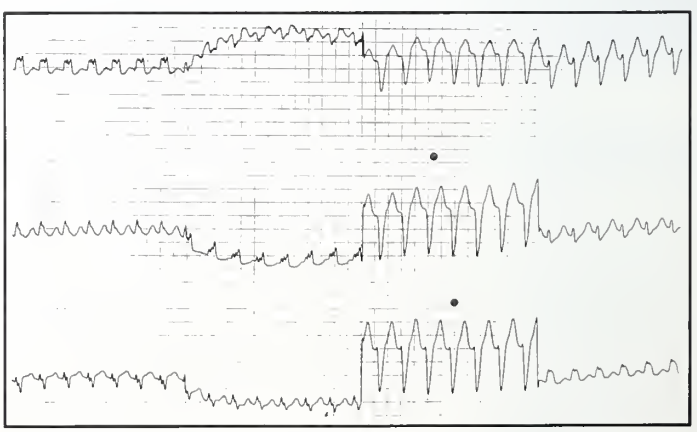


FIGURE 2. The EKG of the patient in Case 2.

TABLE 1. Misconceptions About Wide QRS Tachycardias

1. A normal blood pressure is very strong evidence for a supraventricular mechanism.
2. A 1:1 association between ventricular and atrial activity proves a supraventricular mechanism.
3. A right bundle branch block QRS morphology strongly favors a supraventricular mechanism.
4. Sustained ventricular tachycardia almost never occurs in young healthy patients.
5. Verapamil is safe to give as a routine diagnostic and therapeutic intervention.

[Each of these statements is *false*.]

by our second case. Pulselessness favors a ventricular mechanism, but otherwise the blood pressure is of little use in distinguishing ventricular from supraventricular tachycardia.

Physicians have been trained to look for independent atrial activity "marching through" the ventricular rhythm during wide QRS tachycardias. This "AV *dissociation*" remains a very useful diagnostic observation, and if found, essentially proves that the arrhythmia is ventricular tachycardia. Unfortunately, AV dissociation is not very sensitive, and is recognizable on the surface EKG in only about 20% of cases of proven ventricular tachycardia (2). Less widely appreciated is the fact that half of the cases of ventricular tachycardia have 1:1 conduction from ventricles to atria through the AV node, producing AV *association*. AV association, therefore, does not establish a diagnosis of supraventricular tachycardia, as shown by our first case.

Older criteria for the differential diagnosis of wide QRS tachycardias relied heavily on detailed analysis of QRS morphology (1). Although these criteria can still be helpful, they can also produce misleading results, and are often difficult to remember. Contrary to some perceptions, the mere presence of a right bundle branch block pattern during tachycardia does not by itself favor a supraventricular tachycardia mechanism, since about two-thirds of cases of ventricular tachycardia also follow this pattern (1).

Young and middle-aged patients without a history of heart disease who present with wide QRS tachycardia are often assumed to have a supraventricular arrhythmia. Frequently, however, this is not the case. Several disease processes and arrhythmia mechanisms can lead to ventricular tachycardias in this population, and one should not be persuaded by the patient's age and past history to prematurely exclude the possibility of a ventricular arrhythmia.

Idiopathic ventricular tachycardia in these patients is often exercise-induced, and in about half of cases shows a left bundle branch block morphology with a normal or rightward axis. The latter arrhythmia generally originates in the right ventricular outflow tract (4). It can be successfully treated with catheter ablation, although most of our patients have opted for medical treatment and have remained essentially asymptomatic on beta-blocker therapy.

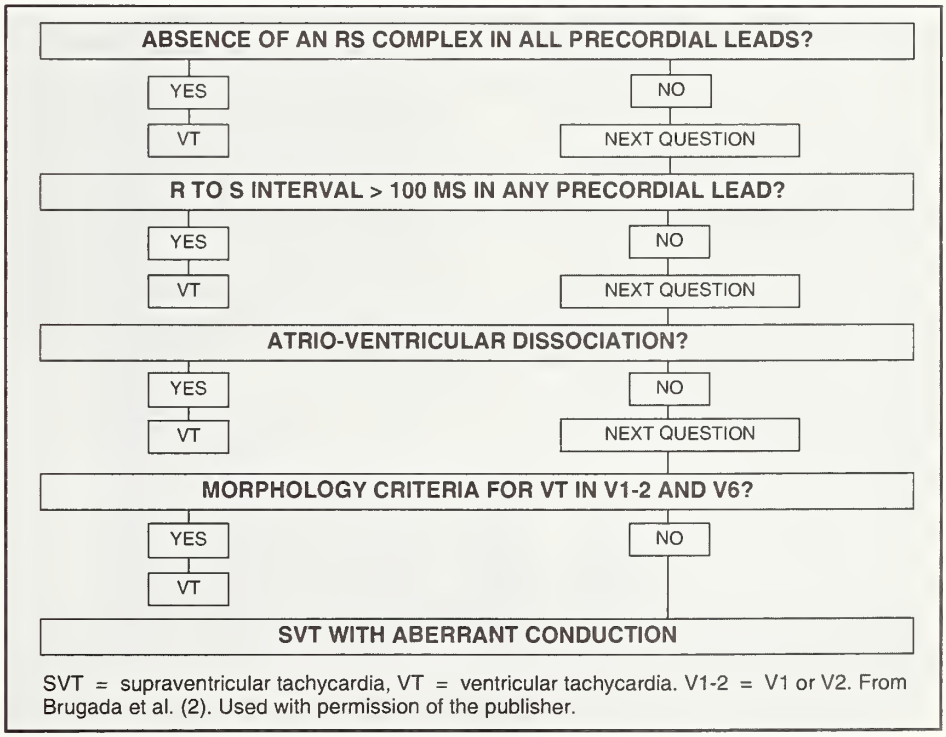
A final misconception about wide QRS tachycardias is that verapamil should be used as a drug of choice for both diagnostic and therapeutic purposes. This practice is not as frequent as in the past, but is still encountered. The danger of this approach is that verapamil often causes hemodynamic collapse when mistakenly given to patients with previously tolerated sustained ventricular tachycardia. Adenosine (6 mg. I.V. push) has a much shorter duration of action than verapamil, and should be used instead when a therapeutic trial is considered warranted. In unclear situations, the Advanced Cardiac Life Support guidelines call for an initial trial of lidocaine (1-1.5 mg/kg I.V. push) before trying adenosine (5).

New diagnostic criteria

In response to the perceived limitations of earlier diagnostic criteria, Brugada and colleagues sought to define a more accurate method for diagnosing wide QRS tachycardias. They developed a four-step algorithm (Figure 3) which we have found helpful and easy to apply.

The first diagnostic step is to examine the precordial (V) leads of the EKG. If none of these shows an RS complex (R wave followed by an S wave), the diagnosis of ventricular tachycardia is highly probable. If one or more RS complexes are present, one proceeds to the next step, which involves measurement of the longest R to S interval present in these leads. This interval is measured from the onset of the R wave to the nadir of the S wave (Figure 4). If this exceeds 100 ms. in any V lead, it argues strongly in favor of ventricular tachycardia. If neither of these two criteria is positive, one proceeds to apply older criteria in a stepwise fashion, looking first for AV dissociation, and if necessary, examining details of morphology.

Applying these criteria in a prospective sample of wide QRS tachycardias, Brugada and his colleagues found a 98% correct classification rate. All of their patients with supraventricular tachycardia and aberrancy had an RS complex in at



SVT = supraventricular tachycardia, VT = ventricular tachycardia. V1-2 = V1 or V2. From Brugada et al. (2). Used with permission of the publisher.

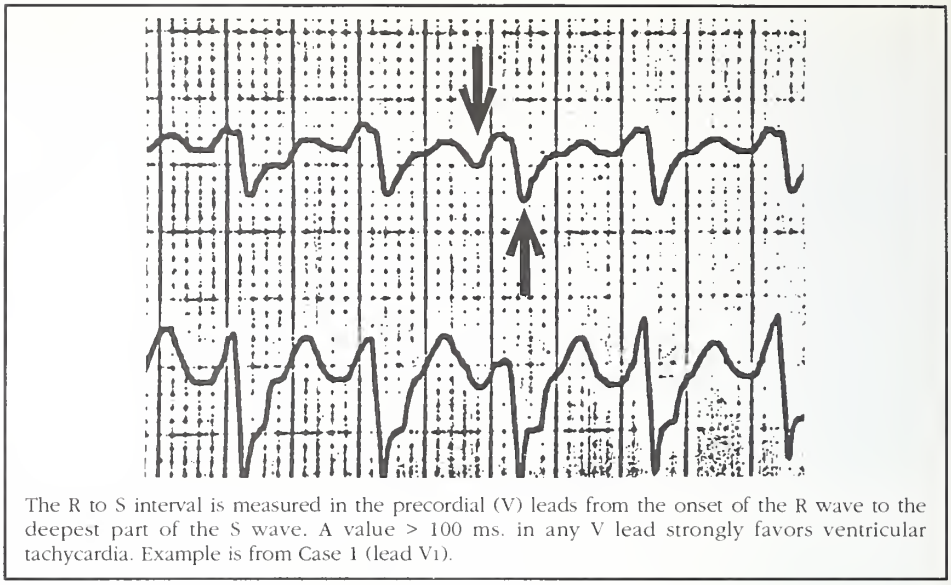
FIGURE 3. Stepwise approach to differential diagnosis.

least one precordial lead, and 26% of their ventricular tachycardias lacked an RS in any of these leads, giving the first criterion modest sensitivity but high specificity for ventricular tachycardia.

We have also found their second criterion (R to S interval) particularly useful. In the Brugada series, none of the patients with aberrancy had an interval > 100 ms., while 52% of ventricular tachycardia patients had an RS longer than 100 ms. in one or more V leads. Again, this criterion shows a moderate sensitivity for ventricular tachycardia with a high specificity. As expected, they found the third criterion (AV dissociation) to be highly specific for ventricular tachycardia, but detected it in only 21% of their ventricular tachycardia patients. If the fourth criterion (morphology) was applied, they required the morphology in both leads V_1 (or V_2) and V_6 to support a ventricular mechanism, otherwise, a diagnosis was made of supraventricular tachycardia with aberrancy. Their morphologic criteria excluded older features such as QRS axis and width, as these were found to have a poor diagnostic specificity.

This algorithm leads to a correct diagnosis in both of the cases we presented. The first patient had an RS interval of 145 ms. on her initial EKG, pointing to the correct diagnosis of ventricular tachycardia. The second patient fulfilled none of the criteria for ventricular tachycardia (longest RS = 70 ms.), and would thus be labeled as having supraventricular tachycardia with aberrancy.

Finally, it remains necessary to "look at the patient," and consider the overall history. About 85% of all wide QRS tachycardias in adults are due to ventricular tachycardia (6). This percentage is probably even higher in patients with coronary disease and prior myocardial infarction. In spite of these odds, there is sometimes a reticence to diagnose ventricular tachycardia, even when this has been proven to be the cause of previous arrhythmia episodes. When all else fails, one will be correct more often than not in diagnosing a wide QRS tachycardia as ventricular tachycardia in a patient with known coronary disease.



The R to S interval is measured in the precordial (V) leads from the onset of the R wave to the deepest part of the S wave. A value > 100 ms. in any V lead strongly favors ventricular tachycardia. Example is from Case 1 (lead V1).

FIGURE 4. Measurement of R to S interval.

Summary

This article has reviewed the differential diagnosis of wide QRS tachycardia. We have found the stepwise approach suggested by Brugada to be very useful. Of the newer criteria that he proposes, the R to S interval of > 100 ms. appears to be a particularly helpful clue favoring the diagnosis of ventricular tachycardia. Hemodynamic stability, young age, 1:1 AV association, and the absence of structural heart disease do not exclude a diagnosis of ventricular tachycardia. Most wide QRS tachycardias in adults are ventricular, and when all else fails, one will be right more often than not in favoring this as the diagnosis over supraventricular tachycardia with aberrancy.

The R to S interval is measured in the precordial (V) leads from the onset of the R wave to the deepest part of the S wave. A value > 100 ms. in any V lead strongly favors ventricular tachycardia. Example is from Case 1 (upper tracing is V_1).

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Results of cancer information assessment of high school students in West Virginia

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Abstract

The "Just Say KNOW To Cancer" education program was implemented in public high schools in Kanawha County, W.Va., to assess students' knowledge of cancer risk factors and to provide an educational program about cancer prevention. An anonymous questionnaire was completed in two urban and six suburban schools by 1,235 students in their classrooms. The responses revealed that only 35% and 10% of students were able to identify two or more risk factors and one American Cancer Society warning sign, respectively. Tobacco was the most commonly identified risk factor, being listed by 64% of urban students, compared to 50% of suburban respondents ($p < .001$). Although 84% of all students correctly answered the question regarding the medical complications of smokeless tobacco, only 39% correctly answered the question relating second-hand smoke as a cancer risk factor. The results of this study indicate the need for cancer education in the high school health curriculum.

Introduction

An estimated 74 million Americans, 30% of the present U.S. population, will eventually develop cancer (1). In addition, cancer is the second leading cause of death for children and the fourth leading cause of death for adolescents (2).

Using data and estimates from Doll and Peto (3), seven cancer risk factors have been identified by Iverson and Scheer (4) that seem to be the most applicable to educational intervention and ultimately, behavior change. These risk factors are identified as tobacco use, alcohol use, diet, reproductive and sexual behavior, pollution, radiation and sunlight.

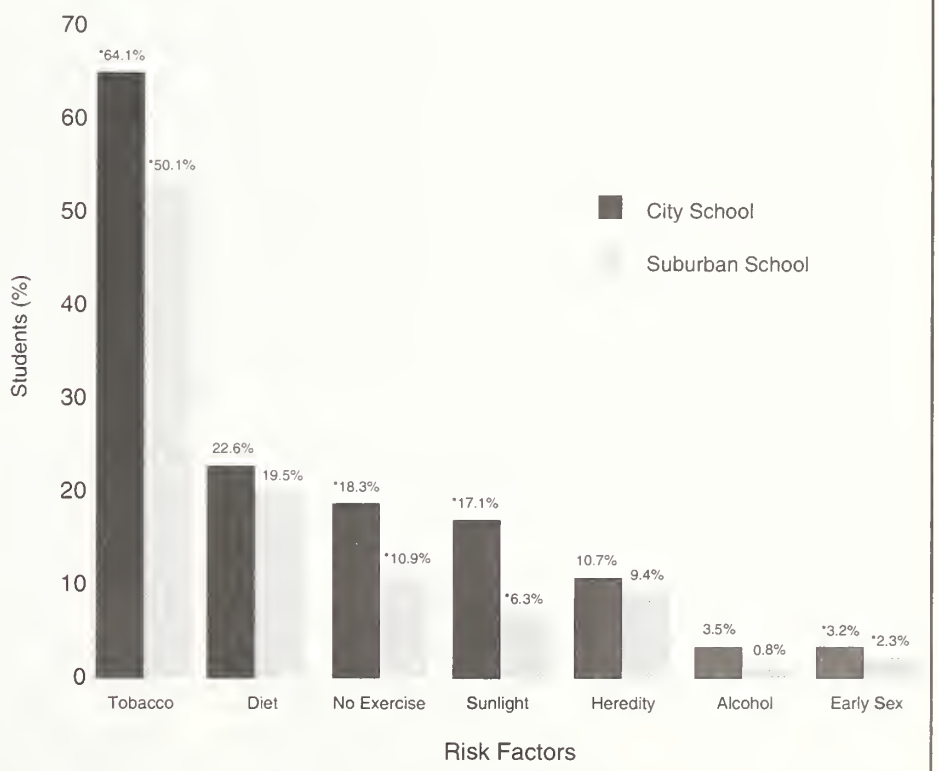
Since children and adolescents are at a stage in life where health attitudes and behaviors are being developed, cancer education programs should obviously be implemented in the school system (5). The *"Just Say KNOW To Cancer"* education program was implemented in public high schools in Kanawha County, W.Va., for students ages 14-17 to assess their knowledge of cancer risk factors and to provide an educational program about cancer prevention which focuses on causes and biology of cancer, substance use, nutrition and eating patterns, and early detection. This article provides the results of this cancer information assessment.

Methods

Ninth and 10th grade students (N = 2,010) in the Kanawha County public schools who were enrolled in either health or biology classes in the 1989-90 school year were asked to complete the *"Just Say KNOW To Cancer"* student questionnaire. This study was designed to obtain a baseline of the student's knowledge of cancer risk factors, cancer warning signs (as cited by the American Cancer Society), and cancer prevention and screening methods. The questions were presented in multiple choice, true/false, and open-ended listing formats.

Initial contact with each school was made with the school principal by the coordinator of the study who was based at Charleston Area Medical Center. The principals were asked to

Figure 1. Cancer Risk Factors Identified



* The difference between city & surburban schools is significant ($p < .10$)

select a "health teacher contact" for the classes involved. The questionnaires were designed to be self-administered in a 15-minute period and returned to the health teacher contact. This teacher contact subsequently placed the anonymous questionnaires in a self-addressed envelope and returned them to the study coordinator.

Results

Completed questionnaires (N = 1,235, or 63%) were received from eight schools (two urban and six suburban).

In response to being asked to list as many as four possible cancer risk factors, only 36% of students were able to identify more than one risk factor. One risk factor was identified by 64% of the students, two by 23%, three by 11%, and four by 2%. The average number of risk factors identified by the urban students ($x = 1.39$) was significantly higher than the average number identified by the students in the suburban schools ($x = 0.99$) (Wilcoxon Rank Test, $z = 5.55$, $p < .001$).

While all cancer risk factors were identified more frequently by students attending the urban schools than by those attending suburban schools (Figure 1), there were significant statistical differences in the risk factors of tobacco use, sunlight exposure, alcohol use, and limited exercise. Tobacco was the most commonly identified risk factor, being correctly listed by 64% of urban students, as compared to 50% of suburban respondents ($x\ 2 = 33.92$, $p < .001$). Diet, hereditary factors, and early sexual activity were the second, fifth, and sixth most frequently identified cancer risk factors by this sample, respectively; and while all were more commonly listed by urban students than by suburban students, the differences were not statistically significant.

Although 84% of all students correctly answered the question regarding the medical complications of smokeless tobacco use, only 39% correctly answered the question relating second-hand smoke as a cancer risk factor (Figure 2). In addition, only 10% of the students were able to list more than one

Figure 2. "Just Say Know To Cancer" Student Questionnaire

	Percent of Students With Correct Answers		
	Overall Students	Urban Students	Surburban Students
1. Cancer is a disease that: a) starts in several locations of the body at the same time. b) is usually caused by an infection. c) is caused by abnormal cell growth. d) is fatal in most cases.	46	50	45
2. Metastasis is: a) a type of cancer. b) a new cancer treatment. c) a term that describes the way a cancer spreads. d) a phase of cell growth.	28	31	56
3. The largest single preventible cause of death and disability in this country is: a) drunk driving. b) cigarette smoking. c) suicide. d) heart disease.	39	49	34**
4. The regular use of smokeless tobacco can cause: a) receding gums. b) wearing of enamel. c) oral cancer. d) bad breath. e) all of the above.	84	90	82**
5. Second hand smoke: a) is called active smoking. b) contains poisonous gases. c) is of no concern, since smoking only affects the person inhaling. d) can cause emphysema and bronchitis, but has no correlation to lung cancer.	39	41	38
6. Which of these foods are highest in fiber? a) cheeseburger. b) pinto beans and cornbread. c) pizza. d) lettuce salad.	56	59	53
7. Which is the more healthy lunch? a) chicken patty on bun with special sauce and cola. b) plain hamburger with mustard, catsup, pickle and 2% milk.	75	79	72**
8. Which contains less fat? a) milkshake. b) frozen yogurt.	88	89	88

* Preferred Answer ** Statistically significant at .05 level

Table 1. Ten Most Frequently Listed Warning Signs

Sign	Percent
Lump	28.2*
Pain	19.2
Sleepiness/fatigue	11.9
Nagging cough	10.0*
Vomiting	9.5
Shortness of breath	8.6
Rashes	6.1
Loss of hair	5.8
Change in wart/mole	5.2*
Diseases	5.1

Table 2. Percent of Students Who Identified American Cancer Society Warning Signs

Sign	%	* Rank
Change in bowel or bladder habits	3.3	14
Sore that does not heal	0	
Unusual bleeding	4.7	12
Thickening or lump in breast or elsewhere	28.2	1
Indigestion or difficulty in swallowing	0.5	30
Obvious change in wart or mole	5.2	9
Nagging cough or hoarseness	10.0	4

* Percentage ranking among 33 signs listed by at least five students

cancer-related warning sign of the American Cancer Society's warning signs; and of the seven warning signs identified by the American Cancer Society, only 25% of the students could identify one and just 10% could name two or more.

Overall the students listed 97 different warning signs, and of the 10 most frequently listed warning signs (Table 1), only three (lump, nagging cough, and change in wart or mole) coincided with the ACS warning signs (Table 2).

Discussion

Several studies have indicated that scientifically accurate knowledge of cancer risk factors and prevention is not commonplace among children and adolescents.

In 1977, a survey by Charlton of 3,537 adolescents who were ages 11-18, found that although 89% mentioned smoking as a cause of cancer, more than half mentioned no other cause (6). Two years later, a study entitled the *National Adolescent Student Health Survey* (7), asked 8th and 10th grade students about the effect of too little fiber in their diets. Sixteen percent stated colon cancer would result from too little fiber in their diet, 17.9% stated high blood pressure would be an effect, 6.4% gave a response of heart problems, and 59.4 % did not know any outcomes that would result from a low-fiber diet.

In our study, only 36% of the students identified more than one risk factor (i.e., smoking, diet, etc.), and only 10% identified more than one cancer warning sign. In addition, only 2.4% of students listed frequent sexual activity as a risk factor for cancer. This latter finding is noteworthy since West Virginia has a higher than average rate of cervical cancer mortality in the United States (8). In addition, 61% of the students were generally unaware that second-hand smoke was considered a cancer risk factor, but this may be due to the fact that data concerning the dangers of second-hand smoke has only recently been provided to the public by the scientific community.

The authors noted apparent confusion by the students with their understanding and use of the terms "warning signs" and "risk factor" as evidenced by examples of the warning signs frequently listed: pain, sleepiness/fatigue, vomiting and rashes. Examples of risk factors listed were heart murmur, hair loss and low weight.

Much of the cancer education in the schools has been an outgrowth of American Cancer Society's programs. Due to the heterogeneous nature of the American school system, it has been difficult to measure the quantity and quality of these programs. Nevertheless, a variety of cancer education and evaluation programs directed toward the adolescent population have been developed, including the *School Health Curriculum Project* (9), the *Know Your Body Program* (10), and *Project Choice* (11). All of these prevention-oriented curricula have been extensively evaluated and found to be successful in modifying students' knowledge, attitudes and behavior.

The *"Just Say KNOW to Cancer"* project has provided the first cancer education program and assessment questionnaire for adolescents in West Virginia. This questionnaire was designed to maximize validity by volunteer participation and the assurance of anonymity. Major limitations of this study include the absence of post-program knowledge assessment and involvement of a limited student population (i.e. only 9th and 10th grade students), but the results clearly indicate the need for cancer education in high schools in the state.

Acknowledgement

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Medical Grand Rounds

Robert C. Byrd Health Sciences Center of WVU

Edited by Irma H. Ullrich, M.D., Professor of Medicine, Section of Endocrinology and Metabolism

Staphylococcus aureus: A continuing problem

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Abstract

Caution is required in managing any immunocompromised host, not only because these patients will be carriers, but because they are also very susceptible to infections with S. aureus. These hosts are not candidates for short-course antibiotic therapy, and catheters should be removed when S. aureus bacteremia is diagnosed. The S. aureus cell wall is a major determinant of the host response and the pathogenicity of this organism. The clinician should recognize the three most important toxins produced by S. aureus: exfoliatin, TSST-1, and enterotoxin-B. Toxic shock syndrome can occur in any host, not just menstruating females, and the clinician should be very thoughtful when dealing with any Staphylococcus aureus infections arising from the use of a catheter.

Introduction

Staphylococcus aureus is an innovative microbe that is truly, as Sheagren described it 10 years ago, the "persistent pathogen" (1). Along with E. coli, it is one of the most commonly acquired hospital infections, and the toxins produced by this pathogen are numerous, with new ones discovered yearly.

S. aureus is well equipped to invade minor skin breaks, protect itself from host defenses, reach the blood stream and cause endocarditis or metastatic infections, all the while producing toxins in picogram quantities which cause diseases with extreme consequences. This organism also has enormous adaptive capabilities as evidenced by its history.

This paper presents a case that demonstrates many of the basic science and clinical principles needed to deal with this pathogen. The current literature regarding catheter-associated bacteremia, several relevant clinical infections, methicillin-resistant Staphylococcus aureus will also be reviewed.

Patient presentation

A 40-year old male presented to the Outpatient Clinic at Ruby Memorial Hospital on July 22, 1993, with nausea and abdominal cramping pain that had been present for eight hours. He had experienced similar symptoms two weeks previously, as well as a fever with bloating and gas, but he thought these conditions were related to symptoms his preschool children were having at the time. His past medical history was significant only for a paronychia the previous month which had been treated with an oral cephalosporin.

This patient appeared very ill, curled on the exam table with abdominal pain. The vital signs showed him to be orthostatic and his temperature rose from 37.2°C to 38.5°C within the hour. The chest exam was clear, and the cardiac exam revealed a grade I/VI systolic ejection murmur without radiation. The abdomen was diffusely tender with a few tinkling bowel sounds. Tenderness was variable, but he actually developed rebound tenderness while in the clinic. The rectal exam was negative, and the skin showed no rashes or cellulitis.

Significant laboratory values showed WBC=13,000 with no left shift, hemoglobin of 14.8 gm/dl, and a normal urinalysis. Since there was abdominal pain, fever and rebound tenderness, a CT scan of the abdomen was performed (Figure 1). It showed multiple hepatic defects consistent with abscesses, and the patient was begun on broad spectrum antibiotics including oxacillin (Prostaphlin)® and metronidazole (Flagyl)®.

A CT-guided aspiration of the liver lesions revealed blood-tinged fluid, and the stains showed a few PMN's

Figure 1. CT scan of the abdomen showing a cross-sectional view of the liver. This demonstrates multiple defects (arrows) which on biopsy revealed polycystic liver disease.

and no organisms. Cultures of this fluid were negative, but blood cultures drawn on the day of admission grew Staphylococcus aureus within 48 hours. This patient was considered clinically recovered after a difficult eight-week course of clindamycin (Cleocin)®, but the CT scan of his abdomen showed no change in the liver lesions.

Laproscopic surgery revealed multiple "blue-lake" lesions on the surface of the liver which produced straw-colored fluid when they were punctured. Cultures of this fluid were also negative, but biopsy of these lesions showed multiple epithelial-lined cysts consistent with polycystic disease of the liver. The clinical impression was that the patient became bacteremic from the previous paronychial infection, which seeded one of the liver cysts that subsequently burst, causing a S. aureus peritonitis.

Epidemiology

The history and the epidemiology of S. aureus are inextricably intertwined. In the 1950s, there was a pandemic of serious S. aureus infections following in the wake of resistant organisms. These serious infections occurred in hospitals which had selection pressures on the staphylococcal organisms (because of the widespread use of antibiotics), large numbers of susceptible patients and good carriers (doctors and nurses).

The key to understanding the epidemiology of S. aureus is knowledge of the carrier state (1). The carrier state is usually defined as a positive swab from the nares, axilla or perineal region; and 30% of health care workers will have S. aureus cultured from the anterior nares.

From the nose, the organisms spread to the skin where they may survive for two days (2). Some may be persistent carriers in the perineal or axillary region; persons with abnormal skin are not only carriers but also launch showers of bacteria-laden epithelial cells into the air (3). Transmission by airborne particles and fomites plays little role; and once heavy droplets reach the floor, they usually do not redisperse. Transmission from person to person is thus not an easy process, but dependent upon a susceptible host.

The classic susceptible hosts are persons with atopic dermatitis or eczema (4); and those using needles including diabetics, addicts, allergy and hemodialysis patients (1,5-7). Newborn infants are extremely susceptible to colonization with staphylococcal organisms, as are patients receiving corticosteroids and those with foreign bodies such as skin sutures or plastic catheters (8). The identical organism carried in the nares of a susceptible host will cause his/her systemic disease; e.g. endocarditis.

Microbiology

Staphylococci are divided into three clinically important species: S. aureus which produces coagulase and DNAase; S. epidermidis; and S. saprophyticus which is significant because of its role in producing urinary tract infections in young women.

The typical grape cluster appearance on Gram's stain is a consequence of random cell division in three planes. Daughter cells stick because staphylococci are covered with a carbohydrate surface that forms intercellular bridges, linking the cells into clusters (2).

This reaction may also play a role in the disease process, especially in catheter-related S. aureus infections. The cell wall is composed of unbranched, linked glycan chains cross linked with pentapeptides. This produces a rigid cell-wall polymer called peptidoglycan which enables the organism to survive in harsh osmotic environments; elicit pyrogen; attract PMN's; activate complement; and elicit opsonic antibodies (9).

The other two major components of the cell wall are Protein A and teichoic acid. Teichoic acid is probably important for attachment to mucous membranes, but measurement of teichoic acid antibody has not proved to be clinically useful. Lysozyme (found in tears and saliva) and B-lactam antibiotics are both active at the pentapeptide crosslinks.

Extracellular enzymes and toxins produced by staphylococci are numerous. The enzymes include catalase, coagulase, hyaluronidase, lipases and nuclease (10). The extracellular toxins include alpha and beta toxin which damage cell membranes or degrade sphingomyelin. Important toxins are exfoliatin, enterotoxin B, and toxic shock syndrome toxin-1 (TSST-1).

Host determinants also play a major role in staphylococcal disease (11). Adhesion of the staphylococcal organisms is the first important step and it occurs in nasal mucosal cells, endothelial cells during septicemia, and disrupted skin. Next, the host invades by penetrating the epithelial or mucosal surface; the classical clinical presentation is the patient who develops S. aureus pneumonia after an influenza virus has damaged the pulmonary epithelium, allowing invasion of the staphylococcal organisms.

Chemotaxis must be intact in the host for ingestion and killing of the staphylococcal organisms; Job syndrome and Chediak-Higashi syndrome are the clinical settings in which patients develop recurrent S. aureus infections because of defective chemotaxis of the host PMN's. Rheumatoid arthritis and decompensated acidotic diabetes mellitus are diseases predisposed to staphylococcal infections because of acquired chemotactic defects.

Opsonization also plays an important role in host defense; peptidoglycan and Protein A trigger the complement system so that S. aureus is coated with C3 and IgG. There are no specific opsonization defects that predispose to S. aureus infections. Intracellular killing, if defective, allows recurrent S. aureus infections and is seen in patients with chronic granulomatous disease and lymphoblastic leukemia (11).

A major host determinant predisposing to S. aureus infections is the presence of a foreign body. The predisposition is thought to occur for three reasons: S. aureus is known to produce glycocalyx in the presence of a foreign body (protective slime); phagocytic cells in the area of foreign bodies become incapable of killing; and S. aureus organisms anchor to the fibronectin/fibrinogen complex covering the foreign bodies (8).

Clinical subsets

Skin infections may be separated into localized infections without a rash and skin infections associated with a rash (significant toxin production). Common skin infections include folliculitis, furuncles, carbuncles, and impetigo.

Mastitis caused by S. aureus may be a problem for nursing mothers (10,12). Hidradenitis suppurativa is often caused by S. aureus, and S. aureus wound infections are a serious threat to post-operative patients, especially those receiving orthopedic appliances.

The staphylococcal skin infections associated with significant toxin production are more menacing. Exfoliatin and TSST-1 are the most significant toxins in these clinical problems. Staphylococcal scalded skin syndrome occurs when certain strains of S. aureus produce epidermolytic exotoxins (exfoliatin is the best described) that lead to large bullae and separation of epidermis resulting

in areas of denuded skin. The toxin is thought to disturb the adhesion of cells in the stratum granulosum. The process starts abruptly with a sunburn-like, tender rash which spreads to the entire body. In two to three days, bullae appear and then near total desquamation occurs. Gentle friction on apparently healthy skin will cause it to wrinkle and be displaced (Nikolsky's sign). These patients are managed as burn patients with appropriate antibiotics and fluids (10).

Toxic shock syndrome was first described in menstruating women, but it should be considered in all other patient populations since it can be seen in any clinical scenario where S. aureus is involved (13). This clinical syndrome is thought to be the result of production of the toxic shock syndrome toxin-1 (TSST-1) by certain strains of S. aureus. It is often described as a "superantigen" due to the fact that it can stimulate release of tumor necrosis factor, interleukin-2 and other cytokines in picogram quantities. Along with a blanching erythematous, deep red rash and hypotension, these patients also suffer with intense myalgias, fever, vomiting, diarrhea and mucous membrane inflammation.

Bacteria

The incidence of gram-negative bacteremia has remained stable, but S. aureus bacteremia has risen dramatically in small non-teaching hospitals. Methicillin resistant S. aureus (MRSA) community-acquired bacteremic infections among intravenous drug abusers has also increased significantly (14).

S. aureus bacteremia relates strongly to host susceptibility. The three major risk groups are among patients with defective defenses (diabetes mellitus, PMN defects such as Job syndrome, eczema, transplant recipients, cancer patients, and AIDS patients), patients with catheters or foreign bodies, and intravenous drug abusers.

There are three critical questions that should be asked when dealing with S. aureus bacteremia:

1. Which patients will develop endocarditis?
2. Which patients will develop metastatic infections?
3. How long should patients be treated with antibiotics?

The risk of subsequent endocarditis is reported to vary from 10% to 60%. Nolan and Beaty (15) showed that there are three major risks that predispose a staphylococcemic patient to endocarditis: an absent primary focus of infection; community acquisition; and presence of metastatic sequelae. The increased risk for endocarditis in these clinical subsets is probably explained by the lack of an early diagnosis.

In Nolan's study, 57% of the patients who had no primary focus and also had a community acquisition of the S. aureus infection developed endocarditis. Metastatic sequelae were a weaker risk since 24%-50% of the staphylococcemic patients had metastatic infections without having infective endocarditis. Echocardiographic demonstration of valvular vegetations strongly predicts infective endocarditis in patients with S. aureus bacteremia, but Bayer (16) showed that by combining the three risk criteria previously mentioned with the echocardiographic presence of vegetations, the sensitivity of diagnosing infective endocarditis increased from 70% to 85% with a 100% specificity.

The decision to perform echocardiography on patients with S. aureus bacteremia can be strengthened by these clinical indicators, but no studies to date have given us the definitive answer.

Cather-related bacteremia

In an excellent review of catheter-related infections, Raad (8) described the four most important sources for colonization of venous catheters as skin insertion site, catheter hub, hematogenous seeding, and infusate contamination. The skin insertion site and the catheter hub are by far the two most common sources.

Topical antibiotics, disinfectants, and silver or dacron cuffs decrease the rate of colonization, but plastic transparent dressings increase the rate. The catheter hubs are contaminated from the organisms carried on the hands of health care workers. Hematogenous seeding is described, but rarely seen, and infusate contamination usually occurs in epidemics.

Adherence of the bacteria is the key step in the pathogenesis of catheter-related infections. In reaction to a foreign body, the host produces a biofilm composed of thrombin, fibrin and fibronectin while S. aureus produces glycocalyx (slime). Together these entities enhance adherence of the organisms and protect the embedded organisms from antibiotics, PMN's and antibodies (8). The type of catheter material is also important since organisms adhere to polyvinylchloride better than Teflon (17). The complications of catheter-related infections include metastatic infections, abscesses, septic emboli, endocarditis, fatal sepsis, septic thrombosis, and the problems and expense of inserting a new catheter.

There are two pertinent clinical questions in the management of catheter-related S. aureus bacteremia:

1. Should the catheter be removed?
2. What is the length of antibiotic therapy?

Raad and Bodey (8) feel that proper management depends on the extent of the infection (local or systemic), the microorganism involved, the type of catheter (surgically implantable or percutaneous non-tunnelled), and the clinical status of the host.

Most authors now agree that the catheters must be removed in all cases of S. aureus catheter-related bacteremia. There is no disagreement that the catheter must be removed if the patient remains febrile for 72 hours after antibiotics are started, if there is persistent bacteremia, or if tunnel pus can be demonstrated (8,10,18). Dugdale and Ramsey have shown that for Hickman-related S. aureus bacteremia, there is an increased incidence of sepsis-related death if the catheter remains (18). In addition, Raad also recommends removal of the catheter in any immunocompromised host (8).

Length of therapy is also an important question. One quarter of these patients have complications and one in seven dies. The conventional wisdom was that patients with catheter-related S. aureus bacteremia should receive 4-6 weeks of antibiotic therapy because of presumed concomitant infective endocarditis. Ehni and Reller (19) studied two weeks of therapy and found that there was a 20% overall complication rate; and that 9% of patients developed infective endocarditis, and 11% developed a metastatic infection.

Ehni and Reller felt that the following factors may indicate that short-course therapy is appropriate:

1. Removal of the catheter at the time of diagnosis of bacteremia.
2. Absence of valvular heart disease.
3. Rapid defervescence with antibiotic therapy.
4. Lack of immunosuppression.
5. Administration of a full 14-day course of antibiotics.

Jernigan and Farr also reviewed short-course therapy in 1993 (20). They suggested that "the optimal duration of treatment remains unknown" and that randomized trials were required to draw a valid conclusion (20).

Staphylococcus aureus can infect any organ system. The incidence of S. aureus as the infective agent in surgical series and in spontaneous bacterial peritonitis is reported to be around 10% (21), but S. aureus is the most common infective agent in patients undergoing continuous ambulatory peritoneal dialysis (83% in many series) (22).

Staphylococcal pneumonias can be separated into the two clinical categories of either inhalational or hematogenous. There is a close association of inhalational S. aureus pneumonias and outbreaks of influenza in the community, and since the mortality of S. aureus pneumonia is 30%-50%, a positive sputum culture for S. aureus in a patient with influenza should be taken quite seriously.

S. aureus inhalation pneumonia also occurs in hospitalized patients who are prone to aspiration and those who acquire the organism during intubation. In these cases, there is no classic pattern on the radiograph since there can be local consolidation, patchy infiltrates, or lung abscesses. Patients with cystic fibrosis have frequent episodes of pulmonary compromise that can be attributed to S. aureus and must be treated aggressively with appropriate antistaphylococcal agents.

S. aureus pneumonias may also be caused by hematogenous seeding of the lung parenchyma. The classic clinical presentation is the S. aureus pneumonia associated with right-sided endocarditis in an intravenous drug user. Similar pneumonias can also be seen in hospitalized patients with infected catheters, dialysis devices, or infected thrombotic material (10). Hematogenously-spread S. aureus pneumonias are also a common cause of pleural empyema.

Staphylococcus aureus osteomyelitis is also a frequent and difficult problem to manage, with some hematogenously spread and others developing because of a contiguous focus. Bacteremia in adults rarely leads to osteomyelitis in long bones, but vertebral osteomyelitis is more common. In one large survey in 1980 (23), S. aureus was the infective agent in 60% of the cases of vertebral osteomyelitis. Vertebral osteomyelitis usually presents as a febrile episode with excruciating back pain; early bone scan is the preferred diagnostic test, but needle aspiration for diagnosis is often necessary.

Another common clinical presentation is the S. aureus osteomyelitis that develops from a contiguous focus as the result of orthopedic surgery or trauma, or in association with a diabetic foot ulcer (2,10). In these situations, bone samples may be needed for diagnosis, and critical decisions are often made concerning removal of prostheses.

S. aureus bursitis should also be mentioned since 90% of cases of infective bursitis are caused by this organism (10). The olecranon and the prepatellar bursae are the most common sites, and the overlying skin is hot, red, and edematous, but the underlying joint moves freely. Treatment includes antistaphylococcal antibiotics as well as repeated aspirations of the infected bursae (10).

Another type that deserves attention is staphylococcal food poisoning. This disease involves person-to-person transmission; usually a food handler who is a carrier of a pathogenic strain of S. aureus contaminates food which is subsequently improperly stored. The staphylococci subsequently multiply in the food substance and produce the heat stable enterotoxin B which is ingested. This enterotoxin causes acute salivation followed by nausea and vomiting, and then abdominal cramps and diarrhea. The symptoms appear two to six hours after ingestion of the toxin-laden food (depending on the amount of toxin ingested) and symptoms are usually limited to 24 hours (1,10).

Methicillin resistant S. aureus (MRSA) is a special problem. The precise mechanism of resistance to methicillin and other B-lactam antibiotics is unknown, but the presence on the membrane of a novel, penicillin-binding protein that is insensitive to B-lactam antibiotics is at least partly responsible.

There is a wide body of literature describing the problems and possible mechanisms of control of MRSA in our hospitals (24,25). Due to the virulence of this organism, its increasing prevalence not only in hospital settings but now in community settings (24), and the lack of effective antibiotics other than vancomycin (Vancocin)®, it behooves us all as clinicians to participate fully in the control measures instituted by our hospitals.

Although laboratories may report some susceptibility of these organisms to the cephalosporin or tetracycline class of antibiotics, the clinician should not be fooled into using these antibiotics when methicillin resistance is reported from the laboratory.

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James L Comerci M.D.

Making a difference

By now I'm sure that most of you have become thoroughly frustrated with the health care debate. Not only are you bombarded with the media's coverage of it, but it is probably affecting you and your patients personally.

As physicians, it is very frustrating and frightening to imagine how our practices may change. Just as we must daily face these uncertainties, so must our patients. They too, are scared and unsure of what may be happening to their health care system.

Will I still be able to choose my own physician?

Will I still be able to select my own type of insurance coverage?

What kind of benefits will I have if health care reform passes?

These are just a few of the questions I am constantly asked by my patients, and it is up to all of us to make sure we will have answers that will be acceptable to both ourselves and our patients. How can we accomplish this?

In the next several months, we will have some excellent opportunities to become more involved in the debate over health care reform and influence the policies of both the WVSMA and the AMA. Several of us have recently returned from representing the WVSMA at the AMA's Annual Meeting, where we were involved in many discussions concerning health care reform and the AMA's policies. I would encourage you to again read the *Patient Protection Act* that was recently sent to you by the AMA. This is a very powerful program that will protect patients and will continue to allow physicians to have a voice in health care delivery. It has been accepted quite well by many members of Congress and will ensure that the AMA remains involved in the health care debate.

On the state level, we have been very successful in the recent primary election and are beginning to plan endorsements for this fall. You can be involved in WESPAC through the $365 Club or other contribution levels, and you should also participate in your upcoming general election in some manner. Regardless of how you choose to become involved, there is no question that you need to make political activity and political action part of your life as a physician.

Another reality of practicing medicine in today's world, is your involvement with your local component medical society and the WVSMA. We are less than two months away from the WVMSA's Annual Meeting, a critical event for all members because the Council and the House of Delegates will both convene and you will have an opportunity to mold the WVSMA's policies. I encourage you to submit resolutions and the make sure that your county is represented with members at both the Council and the House of Delegates meetings.

The WVSMA is only as strong as its individual component societies, and it is only as strong as the commitment of our members on a grass roots basis.

James L. Comerci, M.D.

WESPAC – Now more than ever

The primary election in West Virginia has come and gone. Sixty-six of the 85 candidates WESPAC endorsed won in their races. Not only was it significant that so many of our endorsed candidates were successful, but also that for the first time in a number of years, we were able to contribute significant sums of money to their campaigns, nearly $30 thousand.

Of additional importance is the fact that we should have a similar amount to spend in the general election in November. We have these financial resources thanks to some arm-twisting by a few members and WVSMA President Dr. Jim Comerci's innovative program of *"A Dollar A Day."* In response to this challenge, many members have increased their contributions from the minimum of $50 to $365.

Regrettably, a few officers of the WVSMA and about a third of the Council members have yet to make a contribution. Shouldn't every WVSMA leader and member belong to the $365 Club? I certainly think so!

Growing up in southern West Virginia acquaints one early with the realities of politics in our state. The saying, *"Vote early and vote often,"* was not merely an attempt at political humor, but a mentality that still persists today.

Our profession is currently being assailed on every side by the president of the United States, our junior senator, PEIA, Medicaid, insurers, various politicians, activist groups, and even by our own patients who are demanding more and better care at lower costs. We have no choice but to try to defend our right to practice medicine in a reasonable fashion by preserving our right to continue the traditional physician/patient relationship, and by preserving our right to set our own fees and earn a fair wage for our services.

To achieve these goals, we must first begin by educating our patients to the realities of the costs of medicine and technology, not only by talking to them on a personal basis, but by providing them with copies of articles such as *"Your Risk Under Clinton's Health Plan,"* which appeared in *Reader's Digest* this February, and *"Here's Health-Care Reform That Works,"* which was published by *Reader's Digest* in October 1993. Another important item which your patients should read is the full page ad by neurosurgeon Dr. Gonzalo Sanchez, which was published in the February 12 issue of the *South Dakota Argus Leader*. (Call me at 842-3446 and I'll send you a copy.)

In addition to better educating our patients, we must see that the members of our Legislature are people who are informed about the realities of medical care today and the realities of the proposed health care plans. Unfortunately, the only way we can do this is by political action, i.e. by seeing that people who favor our positions are elected, and that those who are obviously opposed to the private practice of medicine are not elected.

We have very few avenues to that end, therefore, I encourage you to give individual contributions to those candidates who are friendly to our cause or who are opposing candidates hostile to it. By making individual contributions, as well as $365 contributions each year to WESPAC, we will enable our officers and lobbyists to be heard when they approach members of the Legislature about medical matters.

With the threat of an unacceptable form of health care reform rapidly approaching, this may be our last chance to make a difference. Time is running out -- so join WESPAC today!!!

Douglas E. McKinney, M.D

Intercepted Mail

April 28, 1994

Ms. Sonia Daugherty, Special Assistant
Public Employees' Insurance Agency
State Capitol Complex
Building 5, Room 1001
1900 Kanawha Boulevard, East

Dear Ms. Daugherty:

This letter is to more formally record my protest to the PEIA, Workers' Compensation, and Office of Medical Services of WVHHR's decision to reimburse non-physician providers at parity with physicians as indicated on page 3 of the physicians' payment policy to accompany RBRVS fee schedules dated April 22, 1994. I would challenge your statement that there was a balanced discussion and perspectives offered by physician and non-physician Technical Advisory Panel members as clearly the physician majority of the panel did not feel that parity was warranted in the situations discussed.

The main issues involved obstetrical services provided by midwives and psychotherapy services provided by psychologists or social workers. To reiterate the discussion and the conclusion of the majority of the panel, non-physician providers do not possess the same level of training or expertise in performing these procedures as physicians do. I frankly believe that the administrators involved in these decisions have little appreciation of the time and effort that goes into becoming a physician. To reimburse individuals who have spent far less time, money, and effort to achieve their midwife, psychology, or social work status at the same level as a physician, will clearly have a long-term impact on the recruitment of qualified individuals into the medical field, particularly in the areas of obstetrics and psychiatry.

The primary factors that the payors cite leading to the decision of parity are bogus. Many non-physician providers do in fact bill the payors independently and are not in the employment of physicians. Those who arrange consultive or supervisory time with physicians do so only because of demands placed by insurance carriers for physician input in the care of the patient. Frankly, with at least some non-physician providers in the area of mental health, I clearly feel this policy is a good one that insures a higher quality of care for the patient.

Sincerely,

T.O. Dickey III, M.D.

cc: David Lambert, PEIA
Jimmy Mangus, M.D., Office of Medical Services of WVHHR
Andy Richardson, Workers' Compensation
James Comerci, M.D., President WVSMA
John Vanin, M.D., President WVPA
Michael Lewis, M.D.
Stephen Ward, M.D.

WHAT YOU DON'T KNOW CAN HURT YOU.

That's why Congress *must* pass the Patient Protection Act.

There are things insurance companies don't want you to know about their health plans. That's why you need the facts. So you can make informed choices and get quality care in spite of their efforts to keep you in the dark.

The Patient Protection Act will require insurance companies to give you all the information you need *before* you join a health plan. They'll have to tell you what is and isn't covered in their plan. What sort of incentives they give to limit the care you get. What sort of approval process you have to go through to get the care you need. And how many people have dropped out of their plan because they were dissatisfied with the care they got.

It will also make sure your doctor has a say in your plan's medical policies and make it illegal for your plan to fire your doctor for giving you all the care you need. What's more, it will allow you to choose your *own* doctor – instead of having one chosen for you.

In short, the Patient Protection Act requires insurance companies to give you a full explanation of how their plan's limitations affect you. So you and your family can make an informed, intelligent decision about the one thing that's more important than any other. Your health.

This is the moment of truth. Call your senators and representative now. Demand that they support the Patient Protection Act. Because when you're dealing with the insurance industry, what you don't know really can hurt you.

American Medical Association
Physicians dedicated to the health of America

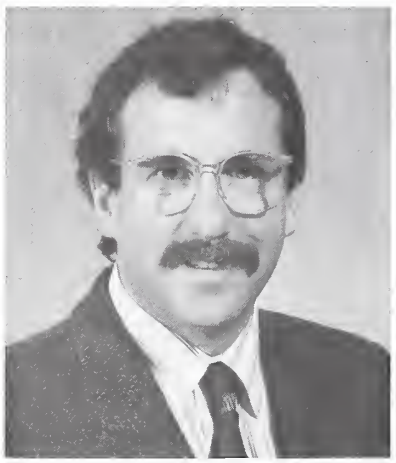
At Annual Meeting

General Scientific Session to focus on prevention, treatment of peripheral vascular disease

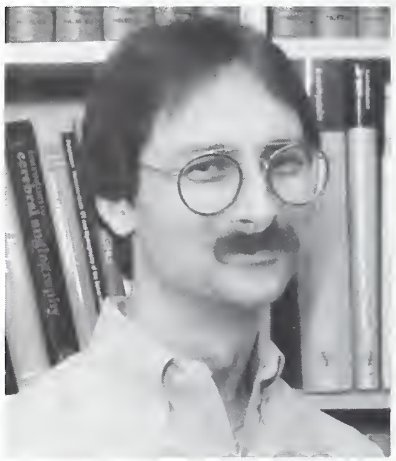
Four diagnostic specialists will present lectures on the topic of *"Peripheral Vascular Disease– Prevention, Medical/Surgical Management and Rehabilitation"* for the General Scientific Session, which will take place on Thursday, August 18 from 8:30 a.m. - noon during the WVSMA's Annual Meeting at The Greenbrier.

Scheduled to join Moderator Dr. John D. Holloway for this session are Jeffrey W. Olin, D.O., F.A.C.P., associate program director of the Internal Medicine Residency Program for the Cleveland Clinic Foundation; Peter Kim Nelson, M.D., assistant professor of clinical radiology at New York University Medical Center; C. Douglas Phillips, M.D., assistant professor of the Department of Radiology, Neurosurgery and Otolaryngology at the University of Virginia Health Sciences Center; and William F. Ruschhaupt III, M.D., a staff physician in the Department of Vascular Medicine at the Cleveland Clinic Foundation.

Information about these four speakers begins below. A registration form for this year's WVSMA Annual Meeting is printed on page 249, and more details can be obtained by phoning Nancie Divvens at (304) 925-0342.



Dr. Olin



Dr. Phillips

Speakers highlighted

Dr. Olin received his D.O. degree in 1977 from the Kansas City College of Osteopathic Medicine in Kansas City, Mo. He interned at Grandview Hospital in Dayton, Ohio, and completed a three-year residency at the Cleveland Clinic Foundation, where he served as chief medical resident.

From 1981-83, Dr. Olin served as a fellow in hypertension and nephrology at the Cleveland Clinic Foundation. Following his fellowship, Dr. Olin joined the faculty of the Department of Medicine, Division of Nephrology at The Western Pennsylvania Hospital in Pittsburgh. During his three years at the hospital, Dr. Olin also served in other capacities, including director of the Hypertension Clinic, associate program director of the Internal Medicine Training Program, and co-chief of the Subdivision of Nephrology.

Dr. Olin relocated to Cleveland in 1986 to become an associate staff member in the Department of Vascular Medicine at the Cleveland Clinic Foundation. The next year, he was promoted to head of the Section of Atherosclerosis and Lipids and was also named program director of residency training for the Department of Vascular Medicine.

In 1992, Dr. Olin accepted his current post as associate program director of the internal medicine residency in the Division of Medicine at the Cleveland Clinic. In addition, he is also an associate professor of medicine at Ohio State University and a professor of medicine at Penn State University.

An associate editor of the *Journal of Vascular Medicine and Biology*, Dr. Olin also serves on the editorial board and is a reviewer for the *Cleveland Clinic Journal of Medicine* and several other medical publications. He is a diplomate of the American Board of Internal Medicine and the American Board of Nephrology, and is a fellow of the American College of Physicians and the American College of Cardiology.

Dr. Nelson obtained his medical degree in 1986 from the Louisiana State University School of Medicine in New Orleans, where he received The Adamo Award in Neuroscience and the Medical Pharmacology Award. He interned at Barnes Hospital in St. Louis and then completed a three-year residency in radiology and a two-year fellowship in diagnostic radiology at the Mallinckrodt Institute of Radiology in St. Louis. In addition, while working on his fellowship at Mallinckrodt, Dr. Nelson also completed a one-year fellowship in interventional neuroradiology at New York University Medical Center.

In 1992, Dr. Nelson assumed his present position as an assistant professor of clinical radiology at New York University Medical Center. He also serves as an assistant attending in radiology at both Tisch Hospital and Bellevue Hospital.

Dr. Nelson has had articles printed in several medical journals, as well as written book chapters and abstracts for a variety of scientific publications.

Dr. Phillips served at the U.S. Air Force Academy from 1977-78, and then attended Marshall University where he received a Regents B.A. degree in 1981 and his medical degree in 1984. He completed his postgraduate

training at the University of Virginia Medical Center as a resident in diagnostic radiology from 1984-87; as academic chief resident from 1987-88; as a fellow in neuroradiology from 1988-89; and as an instructor in neuroradiology from 1989-90.

Before he accepted his current role as an assistant professor of radiology, neurosurgery, and otolaryngology - head and neck surgery at the University of Virginia Health Sciences Center, Dr. Phillips held locum tenens positions at four hospitals in Virginia.

A diplomate of the National Board of Medical Examiners, Dr. Phillips is certified in diagnostic radiology by the American Board of Radiology, and is a senior member of the American Society of Neuroradiology.

Very active on committees at the University of Virginia, Dr. Phillips has served as a visiting professor at Eastern Virginia Medical School and has lectured extensively at medical meetings in Virginia and throughout the United States.

Dr. Ruschhaupt is a native of Pittsburgh who obtained his medical degree from the University of Pittsburgh in 1972. He completed an internship in internal medicine at Dallas Veterans Administration Hospital at the University of Texas Southwestern, and then did a two-year residency in internal medicine at the Cleveland Clinic Foundation.

After his residency, Dr. Ruschhaupt joined the U.S. Army and served as chief of Emergency Medical Services and chief of the Peripheral Vascular Disease Clinic at Tripler Army Medical Center from 1975-78. After his army duty, Dr. Ruschhaupt accepted his current position as a staff physician at the Cleveland Clinic Foundation. In 1985, Dr. Ruschhaupt received an M.B.A. degree from Case Western Reserve University in Cleveland, and during his years at the Cleveland Clinic Foundation he has also held positions as program director of Patient Care Systems and project director of the Patient Financial Services' Systems Implementation Project.

A diplomate of the American Board of Internal Medicine, Dr. Ruschhaupt is also a member of the American College of Physicians, the American Heart Association, the American Society of Internal Medicine, and the Society of Vascular Medicine and Biology. A trustee of Ronald McDonald Children's Charities and Children's Oncology Services of Northern Ohio, Dr. Ruschhaupt is also president of the Ohio Society of Internal Medicine.

Special evening of dancing, comedy planned for Annual Meeting

The musical group *"Good Time Jazz"* will kickoff a lively evening of free entertainment at 9 p.m. on Friday, August 19 during the WVSMA's Annual Meeting at The Greenbrier. In addition to the dance music, humorist Pat Leimbach will also entertain guests with her *"Wit of the Country."*

"Good Time Jazz" is a band which plays a variety of music including Ragtime and Dixieland, Swing and the Big Band Era, as well as the standards of the 50s through the 90s. This band is under the direction of Dr. George West from Harrisonburg, Va., and features many musicians who are also members of Hal Walls Orchestra, which regularly performs at The Greenbrier.

Leimbach is a farm wife from Vermilion, Ohio, who is a partner with her son in a potato, vegetable and grain operation. She writes a newspaper column called *"Country Wife"* which appears in a number of farm publications around the nation. Leimbach is also the author of three books, *"A Thread of Blue Denim,"* *"All My Meadows,"* and *"Harvest of Bittersweet."*

The Wall Street Journal in a front page feature referred to Leimbach as "the Erma Bombeck of the Farm Belt." She subsequently appeared on *"Good Morning America"* with Bombeck. Leimbach has also been a guest on the *"Today Show,"* *"Larry King Live,"* and PBS-TV's *"Market to Market."* She has entertained audiences in 45 states and four Canadian provinces with her *"Old Farm Wives Tales."*

Leimbach

A graduate of Case Western Reserve University, Leimbach did graduate study at McGill University in Montreal. She was a modern language teacher in her home county for several years and is a member of the Associated Country Women of the World, the Ohio Agricultural Council, Women for Ohio Agriculture, and the American Agri-Women. She was appointed by Secretary of Agriculture Bergland to the Project for Women of the USDA.

WVSMA endorses new OSHA training kit by Current Concepts

Current Concept Seminars, Inc., has developed *"The Complete OSHA Training Kit,"* a videotaped lecture presentation with trainer's text designed to simplify the task of employee training under the OSHA Bloodborne Pathogens Standards and the OSHA Hazard Communication Standards. This training kit has been endorsed by the WVSMA and is available to members for $79.

Last year over 25 national and state professional associations endorsed Current Concepts' compliance manual entitled *"Infection Control in Healthcare,"* in order to help notify their members of the Bloodborne Pathogens Standards.

To order this new training kit, phone Current Concepts at (904) 620-8905. Please specify when you place your order, that you are a member of the WVSMA.

Special honor

W. Warren Point III, M.D., of Charleston, proudly holds the William J. Maier Jr. Education Award for 1993-94, which he received for the outstanding contributions he has made to education in the health sciences. This annual award is sponsored by the Robert C. Byrd Health Sciences Center of WVU and CAMC, and is funded by the Sarah and Pauline Maier Foundation, Inc.

Research Day winners

The individuals who received honors at the annual Research Day competition sponsored by the Charleston Division of the Robert C. Byrd Health Sciences Center of WVU and CAMC were (from left to right) Bryan K. Richmond, M.D.; John V. Onestinghel III, M.D.; Lora L. Thaxton, MSIII; R. Todd DePond, M.D.; Heather L. Mertz, MSIII; Jerry E. Owensby, M.D.; and Kent L. Carter, Pharm.D. Drs. Richmond and Onestinghel were the first and second place winners, and Thaxton was the third-place winner in the category for review/subject presentations. Mertz received the first place prize in the original research category; Drs. Owensby and DePond, tied for second place; and Dr. Carter was presented the prize for third-place.

WPBY-TV sponsoring *"Women's Health Initiative"*

As part of their outreach project, the *"Women's Health Initiative,"* WPBY-TV is broadcasting a series of programs designed to inform viewers of the health problems affecting women in West Virginia. The first shows of this series began airing in May and the remaining schedule of programs is as follows:

June 27 - 10:30 p.m.
"America's Women: In Pursuit of Health"

June 29 - 10:30 p.m.
"Health Chronicles - In Search of a Miracle"

July 3 - 7 p.m.
"A Women's Heart"

July 28 - 8:30 p.m.
"In the Public Interest - Heart Disease"

August 16 - 9 p.m.
"The Famine Within"

August 16 - 10:30 p.m.
"The Famine Within: What is Perfect?"

August 25 - 8:30 p.m.
"In the Public Interest - Smoking"

September 1 - 10 p.m.
"Straight Talk on Menopause 'Signs and Symptoms'"

September 8 - 10 p.m.
"Straight Talk on Menopause 'Taking Charge'

September 22 - 8:30 p.m.
"In the Public Interest - Depression"

October 6 - 8:30 p.m.
"In the Public Interest - Breast Cancer"

October 24 - 9 p.m.
"A Woman's Health

October 27 - 8:30 p.m.
"In the Public Interest - Domestic Violence"

Also airing in October (dates and times to be announced)
"Breast Cancer . . . Speaking Out"

"Breast Cancer . . . Speaking Out . . . Again"

In conjunction with the *Women's Health Initiative,* brochures have been published entitled *"Six Health Issues of Concern to Every Woman."* These brochures are available at district Department of Human Services centers, libraries, women's centers, county health departments, clinics, and doctor's offices. The printing of these brochures was funded by the WVSMA and WVSMAA, and the WPBY-TV Women's Health Initiative Programs have been underwritten by Cabell Huntington Hospital's Women's Health Services. In addition, three WVSMAA members, Jean Skaggs, Bonnie Fidler and Linda Turner are serving on the Women's Health Initiative Advisory Task Force.

For details about the *Women's Health Initiative* and *Community Outreach,* contact Robin Pyle at WPBY-TV, 696-6630.

The West Virginia State Medical Association's

1994 Annual Meeting

August 17-20, 1994

The Greenbrier

White Sulphur Springs, West Virginia

Sign Up NOW!

Please be sure to make hotel reservations in advance by calling 1-800-624-6070. **The Greenbrier will fill up quickly because the State Fair will be going on during the same week.**

Space is being held at other area hotels/motels, contact the WVSMA at 304-925-0342 for more details. For your convenience, you may call the WVSMA office and register for the conference using your Visa or Master Card.

1994 Annual Meeting

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Address _____

City _____ State ____ Zip Code ____

Specialty _____

Phone _____

Payment by: _ Check _ Visa _ MasterCard

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Expiration Date _____

Signature _____

Conference Cost:	WVSMA member	$125	___
	non-member	$175	___
Additional:			
Thursday, Aug. 18			
Learn and Learn	member/non-member	$ 40	___
(CME Credit)	spouse/student	$ 25	___
Friday, Aug. 19			
Lunch and Learn			
(CME Credit)	member/non-member	$ 40	___
	spouse/student	$ 25	___
	TOTAL:		___

If paying by check, please send registration form and check to:
West Virginia State Medical Association
P.O. Box 4106, Charleston, WV 25364

Continuing Medical Education

Listed on this page are some of the upcoming CME programs which will be held in the state. Unless otherwise noted, the events are presented at the location under which they appear.

If you would like to have the CME programs offered by your institution or association for physicians printed in the *Journal* or obtain more details about the meetings listed, please contact Nancy Hill, managing editor, at 925-0342.

Raleigh County Medical Society - Beckley

June 30
"A Current Look at Prostate Cancer," Jim Simon, M.D., 6:30 p.m., Black Knight County Club

West Virginia State Medical Association - Charleston

June 25
"Marbury v. Madison," Holiday Inn, Clarksburg

June 28
"1994 Medical Billing Seminar," Days Inn, Flatwoods

August 13
"Level One Loss Prevention," Beckley Hotel, Beckley

August 17-20
"WVSMA's 127th Annual Meeting," The Greenbrier, White Sulphur Springs

August 27
"Marbury vs. Madison," Radisson Hotel, Huntington

Outreach Programs

Key to Sponsors

★ *Robert C. Byrd Health Sciences Center of WVU, Morgantown*

☐ *CAMC/Robert C. Byrd Health Sciences Center of WVU, Charleston*

Logan ☐ Logan General Hospital, July 15, 11:45 a.m., "Trauma Resuscitation: Optimizing in the Golden Hour," CAMC Trauma Services

Madison ☐ Boone Memorial Hospital, July 12, 6:30 p.m., "Chest Trauma," Frank C. Lucente, M.D.

Man ☐ Man Appalachian Regional Hospital, July 20, 6:30 p.m., "Medical Evaluation of the Sexually-Abused Child," Kathleen Previll, M.D.

Oak Hill ☐ Plateau Medical Center, June 28, 6:30 p.m., "Pediatric Trauma," A. Margarita Torres, M.D.

☐ Plateau Medical Center, July 26, 6:30 p.m., "Lumbar," Constantino Y. Amores, M.D.

Point Pleasant ☐ Pleasant Valley Hospital, July 28, noon, "Medical Oncology Emergencies," Steven Jubelirer, M.D.

Until there's a cure, there's the American Diabetes Association.

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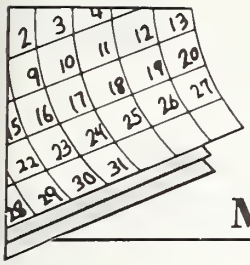
Dr. Mukkamala is a Diplomate of the American Board of Physical Medicine and Rehabilitation and the American Board of Electro-Diagnostic Medicine.

Specialist in Electromyography and Nerve Conduction Studies

For appointment, call: **(304) 344-5153**



Medical Meetings

July

7-8–Second International Conference on the Varicella-Zoster Virus (sponsored by the VZV Research Foundation), Paris

8-9–Using Data to Improve Quality in Healthcare (sponsored by the National Association for Healthcare Quality), Houston

11-13–American In Vitro Allergy/ Immunology Society, Cambridge, Mass.

17-18–2nd Annual Alumni Symposium Featuring the William H. Saunders Lectureship (sponsored by Ohio State University), Galloway, Ohio

August

5-6–Quality Improvement in Healthcare: An Introduction (sponsored by the National Association for Healthcare Quality), Chicago

5-7–2nd Annual Conference of Civil War Medicine (sponsored by the National Museum of Civil War Medicine), Frederick, Md.

8-10–American Hospital Association, Dallas

14-17–Midwest Surgical Association, MacKinac Island, Mich.

17-20–WVSMA's 127th Annual Meeting, White Sulphur Springs

19-20–Healthcare Quality Management: Review and Study Session (sponsored by the National Association for Healthcare Quality), Boston

19-20–Communication Approaches for Tracheostomized and Ventilator Dependent Patients (sponsored by Voicing!, Inc.) Chapel Hill, N.C.

25-27–Southern Association for Oncology, Sea Island, Ga.

26-27–Case Management and Utilization Management in a Changing Healthcare Environment (sponsored by the National Association for Healthcare Quality), Pittsburgh

September

6-11–18th Annual Meeting of the American Academy of Neurological and Orthopaedic Surgeons, Las Vegas

8-10–American Gynecological and Obstetrical Society, Hot Springs, Va.

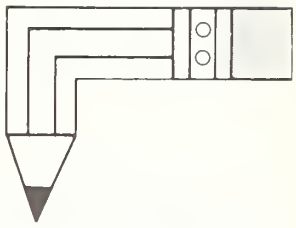
10-13–Seventh Annual Update in Internal Medicine (sponsored by Ohio State University), Columbus

11-14–American College of Emergency Physicians, Orlando, Fla.

16-17–Communication Approaches for Tracheostomized and Ventilator Dependent Patients (sponsored by Voicing!, Inc.), Louisville, Ky.

For More Information . . .

Contact the Journal at (304) 925-0342.



Poetry Corner

Clouds and Dreams

As a child I watched the clouds drift by
In a lazy azure summer sky
Flat on my back in soft green grass
I dreamed of the future and not the past

The day was warm and I remember it well
I can still hear the birds sing, and smell
The scent of rose and purple lavender
As the clouds formed valleys and little hills

I kicked my shoes off and worn socks too
Heard a distant dog's bark and a kitten's mew
Rubbed my toes in the warm moist earth
Watched the clouds coalesce, then disperse

A soft slumber slowly took its place
As the sun danced with shadows across my face
I dreamed of a pond and an old wooden boat
Drifting and rocking for hours afloat

Now the future is here and much older am I
And worn and drained I long for that sky
To capture those clouds, earth, grass and joy
And the innocent slumber I had as a boy.

Phillip V. Swearingen, M.D.

Please address your submissions for Poetry Corner to Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

This page of material is submitted and paid for by the Bureau of Public Health.

Three-year study to look at Lyme disease in West Virginia

Physicians in the state are urged to assist the Bureau of Public Health in a three-year study of Lyme disease and Lyme disease-like illnesses in West Virginia, in order to learn more about the etiology and ecology of this disease.

This study is being conducted by staff with the Bureau's Division of Surveillance and Disease Control in cooperation with WVU's Department of Microbiology/Immunology, the West Virginia Division of Natural Resources and local health departments. It is being funded by the U.S. Centers for Disease Control and Prevention.

Lyme disease is a bacterial infection linked to bites from deer ticks. In 1993, an unusually high number of Lyme disease cases were diagnosed in Greenbrier and Raleigh counties. Yet neither the state nor this region of it have been known to have high deer tick populations. The study will try to determine if more deer ticks exist in West Virginia than previously thought, or if other tick species may carry the bacteria linked to Lyme. It will also find out if ticks transmit other bacteria which may cause illnesses with similar symptoms.

To accomplish these results, ticks found on humans and small animals will be collected to determine their species and what organisms they may be carrying that could cause Lyme or its symptoms. In addition, people who have been diagnosed with or are suspected of having Lyme disease will be needed to take part in the study.

One of the first symptoms of Lyme is a red, bull's eye-type rash, and other early symptoms may include muscle and joint aches, headaches, stiff neck, fatigue, fever, meningitis, and joint pain and swelling. People with these symptoms and those who know they have recently been bitten by a tick should immediately visit a doctor. If they wish to take part in the the study, these individuals will be asked to undergo a series of blood tests, a biopsy and other procedures.

To get a true picture of Lyme in West Virginia, it is imperative for physicians to accurately diagnosis and report this disease. If physicians suspect Lyme diseasse, they should contact their local health department for the Lyme disease study protocol and specimen containers.

For more information, call State Epidemiologist Loretta Haddy at (304) 558-5358 or 1-800-423-1271.

Communities begin program to increase AIDS/HIV awareness

The statewide fight against AIDS and HIV, the virus that causes AIDS, entered a new phase last month when the Bureau of Public Health's AIDS Program sponsored a live, interactive teleconference called "*HIV Prevention Community Planning.*"

Health officials used the broadcast to set in motion a new plan, the community action group or CAG, to coordinate state AIDS strategies with prevention efforts at the local and regional levels. Under this new plan, the state will be divided into eight multi-county regions, each of which will be represented by a CAG. The members of these CAGs will, in turn, elect representatives to a centralized planning group, the West Virginia AIDS Task Force.

Staff are looking for a broad spectrum of people to help organize the regional community action groups, including health care professionals, elected officials, clergy, members of minority groups, lesbians and gay men, parents, and business people, as well as persons who have AIDS or live with someone who has the disease.

For more details about this new plan of action for fighting AIDS and HIV in West Virginia, call the West Virginia AIDS program at (304) 558-2950 or 1-800-642-8244.

WIC celebrates 20 years of service

The West Virginia Women, Infants and Children's Special Supplemental Food Program is celebrating a 20-year track record of providing an effective, cost-efficient wellness program to some of the state's most vulnerable children.

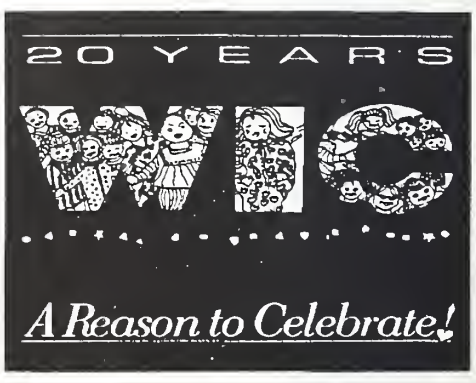
Also known as WIC, this program was first established in West Virginia in May of 1974, and that first year, it served 1,968 participants. In 1994, it's projected that more than 51,000 West Virginians will receive WIC benefits.

The WIC Program educates mothers and mothers-to-be about nutrition and provides drafts for foods rich in calcium, iron, protein and vitamins A and C, in order to improve their health and the health of their children under the age of five.

Studies show that for every dollar spent on a pregnant woman in the WIC program, a total of $3.13 is saved on Medicaid costs in the first 60 days of an infant's life. WIC has also been credited with reducing childhood anemia, low birth-weights, infant mortality and premature births.

To qualify for WIC, a woman, infant or child must first be shown to have a nutritional risk, such as anemia or inadequate diet. The program serves nutritionally-deficient women and children whose family income falls within the 185% of the poverty level defined by the government.

For more information about the West Virginia WIC Program, call Denise Ferris at (304) 558-0030.



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Free Inpatient Treatment Program

For Schizophrenia or Schizoaffective Disorders

Highland Hospital is offering a free treatment program for acute exacerbation of chronic schizophrenia or schizoaffective disorder using an investigational medication.

Interested candidates must be healthy males or females from 18 to 65. Females must be sterile or using acceptable birth control. Candidates must be willing to give informed consent and agree to a four-week hospital stay.

If the treatment is effective, the candidate may continue outpatient treatment with the medication for one year at no cost. There is no charge for the inpatient or outpatient programs.

For more information,
Contact: Charles C. Weise, M.D., (304) 925-2159.

ROBERT C. BYRD HEALTH SCIENCES CENTER OF WEST VIRGINIA UNIVERSITY

Compiled from material furnished by the Robert C. Byrd Health Sciences Center of West Virginia University, Communications Division, Morgantown

Professorship created to honor Dr. Lapp

Lapp

To honor one of its most accomplished faculty members, the WVU School of Medicine created The N. Leroy Lapp, M.D., Professorship in Pulmonary and Critical Care Medicine on May 6.

Dr. Lapp joined the WVU faculty in 1966, while on the faculty of the Appalachian Laboratory for Occupational Respiratory Diseases in Morgantown. He became a full-time WVU faculty member in 1975, and is a professor in the Section of Pulmonary and Critical Care Medicine in the Department of Medicine.

"Dr. Lapp has worked for nearly 30 years to improve the health of West Virginians, and people around the world," said Dr. Robert M. D'Alessandri, dean of medicine and vice president for health sciences. "His work in pulmonary diseases -- especially in research into effects of occupational exposures to lung irritants like coal dust -- has made it possible for WVU to remain a leading institution in the investigation and treatment of lung disease."

"The Best Doctors in America" book lists 10 WVU faculty members

Ten WVU physicians were selected by their peers to be included in the recently published book, "*The Best Doctors in America.*"

The WVU physicians who were listed in the book were included because their peers filled in their names most often on a survey which asked, "If a friend or loved one came to you with a medical problem in your field of expertise and for some reason you could not handle the case, to whom would you send them?"

The physicians featured in the book include: Dr. Lenore Breen, associate professor of neuro-ophthalmology; Dr. Bharati Desai, director of the child/adolescent program in the Department of Behavioral Medicine and Psychiatry; Dr. Robert A. Gustafson, associate professor of pediatric cardiothoracic surgery; Dr. Ludwig Gutmann, professor and chair of the Neurology Department; Dr. Ronald C. Hill, associate professor of cardiothoracic surgery; Dr. Donald L. Lamm, professor and chair of the Department of Urology; Dr. John V. Linberg, professor of ophthalmology; Dr. Gordon F. Murray, professor and chair of Department of Surgery; Dr. Michael I. Sorkin, associate professor and section chief of nephrology; and Dr. Dianne W. Trumbull, assistant professor of behavioral medicine and psychiatry.

Charlton named distinguished teacher

Charlton

Dr. Judie F. Charlton, assistant professor of ophthalmology, has been chosen to receive the 1994 Distinguished Teacher Excellence Award in the WVU School of Medicine.

Dr. Charlton was selected for this honor because of her devotion to improving teaching and her development of the curriculum for a four-year ophthalmology residency. Eight medical school professors were nominated for this award by students and faculty.

During her career at WVU, Dr. Charlton has also been been cited for creating a special training program for ophthalmic assistants and for her involvement in community health. She is a member of the Ophthalmology Residency Review Committee and an examiner for the American Board of Ophthalmology.

Prescott lectures, accepts editorial post

Prescott

Dr. John Prescott, associate professor/ medical director and chair of emergency medicine attended the recent Joint Service Symposium entitled "*Emergency Medicine on the Riverwalk,*" in San Antonio, Texas. Dr. Prescott was one of the several panel members who discussed "*E.D. Management Leading to the Future.*"

In addition, Dr. Prescott was also named associate editor of "*Emergency Medicine,*" a comprehensive textbook to be published by W. B. Saunders next spring. Several chapters to this textbook will be contributed by WVU emergency medicine faculty members.

Junior high teachers to receive training

The HSC's Office for Social Justice has been awarded a $25,000 grant under the Dwight Eisenhower Math and Science Act to establish a Pre-college Health Science and Technology Academy.

The academy will bring 10 eighth grade teachers from Kanawha and McDowell Counties to WVU this summer for training workshops. The workshops will focus on creating hands-on projects in math and science. In addition, the teachers will be trained in multicultural and diversity sensitivity, self-esteem building, leadership and motivation.

Obituary

Daniel T. Watts, Ph.D., 77, founding chair of the Department of Pharmacology in the School of Medicine, died May 11 in Richmond.

Dr. Watts was on the faculty from 1953-66. At the time of his death, he was the retired dean of the Medical College of Virginia's School of Basic Sciences.

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Saturday-Sunday, August 20-21, 1994

Program Director:
C. Frank Lucente, M.D.
Director of Trauma Critical Care
Charleston Area Medical Center

Location:
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Education & Training Center
Charleston, West Virginia

For More Information:

For additional information, please contact the CAMC - Continuing Education and Conference Services Department - 348-9581.

Registration is Limited.

Marshall University School of Medicine

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington

Inco, MU medical cost containment program extremely successful

An innovative health care cost containment program developed by Inco Alloys International and the Marshall University School of Medicine is working so well an Inco executive is recommending it to others -- including Governor Gaston Caperton.

M. E. Cunningham, director of administration for Huntington's Inco plant, said that before "INCOnet Advantage" began a year ago, the company's medical costs were growing four times as fast as inflation. In fact, costs nearly doubled between 1985 and 1992, even though employment dropped.

Unwilling to wait for the government to reform health care, Inco officials approached Dr. Robert Walker of the Marshall School of Medicine about developing a cooperative program. After months of intense work by representatives of Inco, its employees, and Marshall's Department of Family and Community Health, INCOnet was born in April 1993.

Cunningham has been so pleased with the program that he recently wrote a letter to Governor Caperton in which he stated, "We are delighted to recommend this program to people in the business community and would recommend that the state seriously consider the INCOnet Advantage Program as a model for adoption by the PEIA."

With INCOnet, insurance rates actually declined this year for COBRA transitional coverage available to former workers, Cunningham said. The 1 percent decline reversed a three-year upward spiral in which rates had climbed an average of 18 percent a year. The program provides patient care and manages health care services for 1,400 employees at the company's plants in Huntington and Burnaugh, Ky., the workers' dependents, and approximately 150 recent retirees.

"The PPO has allowed us to maintain a high quality of medical care while establishing cost control measures that did not formerly exist," Cunningham said. "Our experience indicates that the concept of using a primary care physician as the gatekeeper of care, which includes the responsibility of managing and tracking specialists and hospital costs, promises to be even more cost-effective and efficient in the future."

According to Walker, INCOnet actually is considered a modified PPO because it is so customized that it does not fit neatly into existing categories of health care plans. Like a PPO, it offers employees lower costs if they use network doctors, who have agreed to provide care within certain financial guidelines. Unlike traditional PPOs, however, INCOnet consists only of primary care physicians. Employees are encouraged to choose a personal or family doctor from a list of about 50 Marshall and private physicians across the Tri-State. Then, when they need surgery or subspecialty care, patients and their doctors can choose any specialist or facility.

"As the trend continues toward managed care, we need to recognize that no one is better qualified to manage a patient's care than the patient and his or her own doctor," Walker said. "If the health care team does need to be expanded, patients and their doctors call the shots in putting it together. We believe that this kind of partnership helps keep costs under control while actually improving patient care," he added.

Rural Datafication Conference features paper by MU faculty

Medical practitioners, faculty and students working in rural areas are increasingly demanding access to cutting-edge computerized information from the field, according to a paper written by Michael McCarty, coordinator for rural health education; Jan I. Fox, chairman of Marshall's Department of Academic Computing; and Arnold Hassen of the West Virginia School of Osteopathic Medicine.

The paper, which McCarthy presented at the Rural Datafication Conference in Minneapolis last month, stated that "The challenge faced by West Virginia and other states is to provide useful, user-friendly resources in a cost-effective and timely manner, and these challenges will continue until and even after the backroads of the 'information highway' are paved."

Educators at West Virginia's health professions schools hope that by providing these technological resources to rural Learning Resource Centers, they will enhance health care education, increase the recruitment and retention of rural practitioners, and improve health care delivery to rural areas of the state," McCarthy said.

Marshall developed its RuralNet computer network several years ago to support medical students doing nine-month rural rotations in the school's Rural Physician Associate Program. The system later expanded to serve all students studying health professions who are taking rural rotations at Kellogg and Rural Health Initiative sites.

Today, electronic information from all West Virginia medical schools is available at the schools and at 16 Kellogg/RHI Learning Resource Centers and more than 100 subsites. Each Learning Research Center has computers equipped for on-line communication and has access to the West Virginia Network for Educational Telecomputing. RuralNet has become the LRCs' primary vehicle for electronic communications and Internet access, McCarthy explained.

Marshall's RuralNet health care information services also will be presented in October at meetings of the American Public Health Association and the Association of American Medical Colleges.

EVEN WITH MS, DONNA MILLER IS SET ON WINNING

Donna was about to become a nurse and a bride. Then she learned she had multiple sclerosis, a chronic disease of the central nervous system. But at 21 she felt invincible to its staggering implications. Now at 28, Donna is quadriplegic and has re-ordered her goals but not her determination to be a winner.

Using specially designed straps and harnesses to permit her to hold a racket and stay upright in her wheelchair, Donna is the only quad player to compete in an Open Division of Wheelchair Tennis. She ranks No. 1 in Doubles and No. 7 in Singles.

Donna is also an executive director of a New York Independent Living Center and a loving wife. While Donna fights to get on with her life, she hopes that a cure for MS will someday be found. The National Multiple Sclerosis Society is bringing that day closer by funding vital research in genetics, virology and immunology. To find out more about the Society and its services, call 1-800-624-8236. Help the quarter of a million Americans with MS help themselves.

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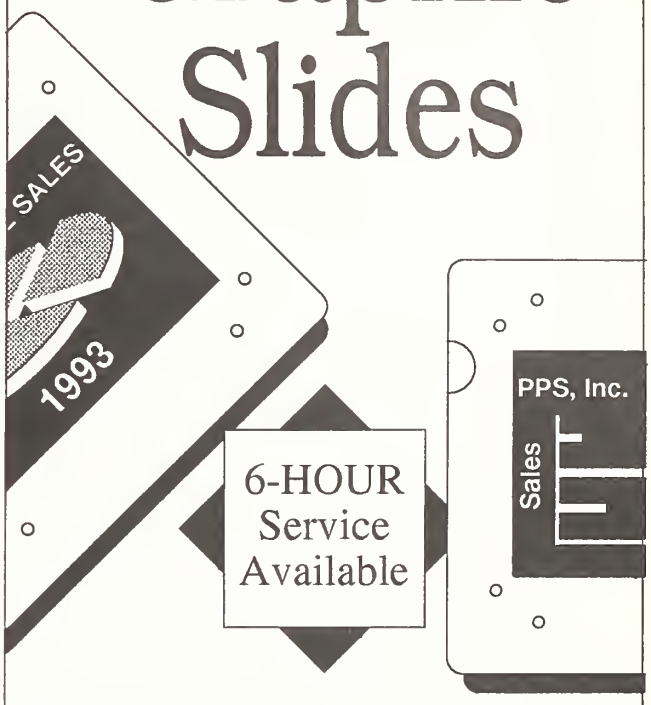

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Alliance News

We finally did it!

The West Virginia State Medical Association Alliance has talked for years about consolidating the annual convention from four days to two days, and at long last we have finally done it.

This year, the Pre-Convention Board Meeting will begin at 10 a.m. in the Fillmore and Van Buren Rooms. The President's Luncheon will follow in the Crystal Room at 12:30 p.m. After this luncheon, the House of Delegates will convene at 2 p.m. During this session, each county president will be allowed to talk for two minutes. Their written reports will be in the booklet given out at the convention.

On Friday evening, the entertainment will be great! At 9 p.m., Dr. George West from Harrisonburg, Va., and his musical group will begin playing a lively variety of dance music. Then at 9:45 p.m., Pat Leimbach from Vermillion, Ohio, will regale us with stories from her past. Leimbach is a journalist, humorist and author, who will have copies of her book to autograph. After Pat entertains us with her ancedotes, Dr. West's musical combo will return so we can continue dancing the night away. The dance and Pat Leimbach's presentation will all be free of charge for guests attending the WVSMA and WVSMAA Annual Meetings, so please plan on being a part of this fun-filled evening!

Saturday morning's schedule will begin early with the Past Presidents' Breakfast in the Washington Room at 8 a.m. The House of Delegates will convene again at 9:30 a.m. with the installation of the new officers and regional directors. Addresses will then be presented by Dr. Robert D'Alessandri, dean of the WVU School of Medicine; Dr. Charles McKown Jr., dean of the MU School of Medicine; Barbara Tippens, AMAA president; and Mildred Taylor, SMAA president.

In the afternoon, the Post Convention Meeting/Luncheon will take place in the Crystal Room at 12:30 p.m. At 2:30 p.m., we will all be ready for some recreation, so we have reserved four courts for tennis and the golf putting area is available. In addition, if anyone wants to hike or play bridge, they are welcome to make their own arrangments. As a special extra attraction at this year's meeting, Jo Ann's Fashions of Beckley will have an AMA-ERF Benefit Boutique set up in the Buchanan Room, which is located next to our main meeting room. Be sure to shop there while you are attending the convention.

Sara Townsend, convention chairman, and Ruth Gilbert, convention co-chairman, have done a tremendous amount of work planning this year's convention. I am very indebted to them and I want to express my heartfelt thanks for a job well done.

It's going to be wonderful! Please be there with me for this special two-day convention.

Sincerely,

Carole Scaring
WVSMAA President

New Members

We would like to welcome the following new members to the WVSMA:

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415 Morris Street, Suite 104
Charleston, WV 25301

Naba Goswami, MD
1025 Main Street #518
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Obituaries

Robert K. Fankhauser, M.D.

Dr. Robert K. Fankhauser, 75, of Hilton Head Island, S.C., died May 1, in Hilton Head.

A longtime Parkersburg physician, Dr. Fankhauser was a native of Vienna who received his medical degree from the George Washington University School of Medicine.

Dr. Fankhauser was a U.S. Navy veteran of World War II and the Korean War. He served as an anesthesiologist and obtained the rank of commander.

During most of his 42-year career, Dr. Fankhauser practiced medicine with a specialty in anesthesiology in the Parkersburg area, serving on the staffs of St. Joseph's Hospital and Camden-Clark Memorial Hospital.

A member of the WVSMA since 1947, Dr. Fankhauser was also a member of the AMA, Parkersburg Academy of Medicine and the American Society of Anesthesiologists. He held a fellowship in the American College of Anesthesiology.

Dr. Fankhauser was an avid golfer and a member of the Parkersburg Country Club, where he was club champion and was a former West Virginia Senior Amateur Champion. He was a member of First Lutheran Church, where he served on the council and taught a Sunday school class for many years.

Surviving are his wife, Katharine H. Fankhauser; three sons, Robert Fankhauser Jr. of Fernadina, Fla., William T. Fankhauser of Hilton Head, and James R. Fankhauser of Vienna; two daughters, Patricia Smollen of Canoga Park, Calif., and K. Susan Fidler of Pittsfield, Mass.; six grandchildren; three stepgrandchildren; one stepgreat-granddaughter; and one sister, Mary Fankhauser Hyland of Marietta, Ga. He was preceded in death by three brothers.

Memorials can be made to the First Lutheran Church, Parkersburg; or the Central Ohio Parkinson Society Inc., 3166 Redding Road, Columbus, Ohio 43221-1951; or the charity of the donor's choice.

Amitava Ghosal, M.D.

Dr. Amitava Ghosal, of Morgantown, died December 2.

Robert C. Lincicome, M.D.

Dr. Robert C. Lincicome, of Vienna, died April 6 at Camden-Clark Memorial Hospital in Parkersburg.

Dr. Lincicome was born in Macksburg, Ohio, and received his pre-med degree from Marietta College and his medical degree from the Duke University School of Medicine. From 1939-42, he served on the staff of Duke University Hospital.

A veteran of World War II, Dr. Lincicome served in the 65th General Hospital Unit in England. After his military duty, Dr. Lincicome moved to Parkersburg in 1946 and opened his office. He was chief of anesthesia at Camden-Clark Memorial Hospital until his retirement in 1981.

A member of the WVSMA since 1946, Dr. Lincicome was also a member and past president of the Parkersburg Academy of Medicine. He was a member of BPOE 198, American Legion Post 15, the VFW, and Westminster Presbyterian Church.

Surviving are his wife, Margaret E. Garrettson Lincicome; three sons, Robert D. Lincicome of Vienna, Charles E. Lincicome of Lewisburg, Pa., and William C. Lincicome of Peachtree City, Ga.; three daughters, Mary Ellen Eddy, Sue Jackson and Elizabeth Ayre, all of Vienna; 13 grandchildren; and two great-grandchildren. He was preceded in death by three brothers and three sisters.

Memorials are preferred to the Camden-Clark Memorial Hospital Foundation or the St. Joseph Hospital Foundation.

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Front Cover

Mountain laurel in bloom at Twin Falls State Park in Wyoming County. Photo courtesy of *Scott Durham* of Pineville.

Dying and death: One physician's perspective

BRUCE A. FOSTER, M.D.
Family Medicine Practitioner, South Charleston; and Attending Physician, Kanawha Hospice Care, Inc.

The first problem with the topic of dying and death is the words. Just scan several dictionaries and you will notice the definitions all emphasize loss, so it seems very difficult to take a positive approach. Decease, demise, dissolution, extinction, departure, loss, passing, lacking power, incapable of being stirred, grown cold, no longer producing, to pass, to disappear, to suffer, to cease; these are words we're familiar with, but their concepts are too narrow. Their definitions only focus on the biological aspects of death or more specifically, dying. To be able to deal effectively with death and dying, we need to broaden our views to realize there is much more to these realities of life than loss.

The appreciation of balance between agony (death struggle) and ecstasy (rapturous delight, a state of trance produced by an overmastering emotion such as joy or adoration) is necessary to successfully deal with death and dying. There is no doubt that dying is not a pleasurable nor desirable activity for any biological organism; death, however, can be viewed as a blessing.

A reframing of our traditional ideas is necessary to realize that there are no deaths, rather graduations to the next step. This concept is sometimes difficult to grasp since we have no experience with the next step, and thus have no sensory data with which we can evaluate it. It is not just faith that gives us an acceptance of afterlife experiences; it is the overwhelming similarity in the reports of afterlife experiences that makes them difficult not to accept. Even though the word or concepts used to describe the experience differ depending upon the cultural context, the uniformity of the graduation encounter cannot be ignored. We still may not appreciate Einstein's Theory of Relativity, but since the transistor radio obviously works we accept it. This same type of principle must be utilized to accept the concept of life after death.

Therefore, the givens in the death and dying equation are these:

(1) Dying is a bitch, but death is a continuation, a new beginning.

(2) Where we are in our life's calendar should determine our approach to dying and death. Early in the spring and summer of our life, avoid dying; but when we get to the last weeks of December perhaps consider embracing death.

Fortunately or unfortunately, activities that surround dying and death don't feel natural, since most of us only get one personal attempt at practice. There are also tremendous sociocultural pressures to avoid the situation altogether.

In the dance of dying and death, there are usually three sets of individuals involved: the one who is dying, their family members and the health care provider. There are also three important variations of the dance. When a person's ship is sinking and they are in the life raft, the alternatives are:

(1) Deny the situation.

(2) Paddle like hell until exhausted.

(3) Lay back and go fishing and enjoy the time that is left. (This is the Hospice concept of care when dealing with terminal patients.)

Ultimately, the patient must be in charge, and be allowed to choose the variation that makes him or her most comfortable. Once identified, caregivers and family should then support the patient's choice even if it's not what they prefer.

As difficult as it is for the patient to accept the reality of dying and death, it is just as difficult for the family. The family must be made aware of one constant; that is a roller coaster of inconsistencies. Family members are not trained, guided or empowered by experience to know that what they're trying to do is correct. It is very difficult to find guidance, but I feel that this poem I wrote two years ago best expresses how to handle this difficult situation:

To The Family of My Dying Patient

You told me you didn't know what to do;
Here are my suggestions:
Realize that our loved one is dying.
Realize their dying is a graduation to something better.
It's the only way to get better.
Remember, Spring follows Winter.
Be with them – it's lonely to die.
Sit with them, touch them, cry with them.
Love them – make them realize they are special.
Review past events, reminisce.
Let them be in charge – follow their choices.
Ask about all the things you're afraid to say.
Deal with the fear of death – with the faith that all will be alright.
Deal with the fear of the situation with knowledge – the truth.
Realize that what you don't do now you can't do later.
And with courage you can do it.

Many caregivers are trained that losing a patient represents failure; this concept obviously needs to be re-examined. Most caregiver-patient encounters are not life and death issues. Fortunately, most of us only encounter the issue of death once and, therefore, the ethics of dying and death may not necessarily apply in day-to-day health issues. However, once the path toward graduation is certain, the rules change.

Pneumonia is a readily treatable disease. Should someone in the early non-painful stage of an expectantly painful disease seek treatment for pneumonia? Should a terminal cancer patient be artificially fed? Should the cancer be fed so it can go on longer? These types of

questions cannot be answered since the answers may change depending upon the belief system of the individual involved.

Remember, each case is different, so decisions should not be made in a "one rule fits all approach." As a practicing physician, my criteria for a successful graduation is to have the patient as pain free as possible, content with their life as it has been, and as accepting as possible of their graduation -- with the family present so they can whisper in the patient's ear they love them as they go. This concept focuses not on the agony of dying but on the ecstasy of death.

Once the patient graduates, the reasons for the definitions of dying and death are now apparent -- the loss. The survivors have loss; the graduate wins. The survivors need the aftercare. Dealing with grief is difficult, but if the survivors are allowed to be honest with their feelings, a resolution through the various stages of grieving (denial, anger, bargaining, depression and acceptance) will be obtained.

Resolution is complete when the survivors can balance the agony of their loss with the ecstasy for the one they have lost; when they can balance the lack of day-to-day presence of the individual with the joy of knowing and appreciating their loved one; when they can feel joy that their loved one still goes on in the afterlife (whatever that is); and when they feel the contentment that everyone participated as they felt they should.

After losing my father to cancer in the early 1990s, his eyeglasses on my fireplace mantel continue to remind me of his vision, the annual fruitcake we still send from him reminds me of his giving nature, and in his old coat I can always find his smell that reminds me of how blessed I was to know him.

Acknowledgments

The author wishes to thank Pat Maddox for the format of this article; Bill French for his feedback; Gary Mears, Ed.D., for his concern; Marlise Foster for her patience; and all his patients for the lessons they teach him every day.

Editor's Note: Excerpts from this article were published in the May issue of Palliation, the newsletter published by Kanawha Hospice Care, Inc.

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Computed tomographic diagnosis of acute blunt pancreatic transection

MARK G. NELSON, M.D.
DAVID R. JONES, M.D.
ALEXANDER VASILAKIS, M.D.
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Department of Surgery, Robert C. Byrd Health Sciences Center of West Virginia University, Morgantown

Abstract

Pancreatic injuries secondary to blunt trauma are challenging to diagnose. In many cases, the diagnosis is missed or delayed due to the subtle symptoms and signs of pancreatic injury. Blunt pancreatic injuries may evolve over a period of time and can be a source of extensive morbidity and mortality. Most radiologic and laboratory studies have been notoriously non-specific in diagnosing pancreatic injuries. This article discusses three patients we treated with pancreatic transection secondary to blunt trauma, who underwent computed tomography (CT) of the abdomen on admission. The pertinent CT findings and utility of CT as a diagnostic tool in these three cases of blunt pancreatic injuries are reviewed. Abdominal CT scanning can accurately identify pancreatic injuries secondary to blunt trauma, allowing expeditious surgical intervention. A high index of suspicion for pancreatic injury combined with careful interpretation of abdominal CT scans can provide valuable information about pancreatic injury during the initial trauma assessment.

Introduction

Pancreatic injury from blunt trauma was first described by Travers in 1827 (1). Current diagnosis of pancreatic injury, however, remains a dilemma for the clinician. Although infrequent, the presence of pancreatic injury must be suspected following an accident with appropriate mechanism of injury. Approximately 3%-12% of patients with blunt abdominal trauma will have pancreatic injuries (1,2,3).

The most common cause of pancreatic transection is related to direct steering wheel injury to the mid-epigastrium (4). The dispersal of energy to the pancreas overlying the vertebral column has been identified as the origin of most mid-pancreatic injuries (1) (Figure 1). Early diagnosis of pancreatic injuries is of utmost importance in preventing the excessive morbidity and mortality associated with delayed diagnosis. Early identification of blunt pancreatic injury requires a high index of suspicion, a carefully planned diagnostic approach and close observation (3). Numerous diagnostic adjuvants have been proposed which can assist in the early diagnosis of pancreatic injury. Many of these diagnostic studies, however, have a low specificity and sensitivity.

The purpose of this study is to review three cases of pancreatic transection and discuss the use of computed tomography (CT) in diagnosing pancreatic injury secondary to blunt trauma.

First case report

A 59-year-old unrestrained female driver was involved in a high speed, head-on, motor vehicle accident. The car sustained heavy damage including destruction of the inner compartment and steering wheel. At the scene, the patient was hypotensive (80/0 torr), tachycardic (124 beats/min.), dyspneic, and complaining of left upper abdominal and chest pain. Two large bore intravenous catheters were placed and fluid resuscitation was begun with crystalloid solution.

The patient was fully immobilized and transported by ambulance to Ruby Memorial Hospital. In the Emergency Department, resuscitative measures were continued, blood transfusions begun and the patient stabilized. A chest roentgenogram showed multiple left rib fractures and widened mediastinum.

Figure 1. Schematic illustration of the intimate association of the pancreas with the vertebral column.

An abdominal CT scan revealed a left pleural effusion, free intraperitoneal fluid, a perisplenic hematoma, and laceration of the body of the pancreas (Figures 2,3). The patient was transported immediately to the operating room. Exploratory laparotomy revealed a Grade III splenic laceration, 2,000 ml. of intraperitoneal blood, and mid-pancreatic crush injury with duct transection. A splenectomy and distal pancreatectomy were performed. Subsequently, an arch aortogram showed an ascending aortic arch tear for which she underwent primary repair.

This patient's hospital course was complicated by the development of a pancreatic fistula which was successfully treated non-operatively. She was discharged after two and a half months.

Second case report

A 34-year-old male sawmill employee was struck in the left upper abdomen and left arm by a board ejected with great force from a cutting machine. Initial evaluation revealed stable and normal vital signs. Physical examination was significant for a 15 cm. transverse, superficial laceration in the left upper quadrant, a diffusely tender abdomen, and an open fracture of the left elbow. Chest roentgenograms showed a left pneumothorax for which a closed tube thoracostomy was placed.

An abdominal CT scan demonstrated a mass near the splenic hilum, an edematous pancreatic contour, and free fluid anterior and medial to the spleen (Figures 4,5). Exploratory laparotomy revealed a near total pancreatic transection, a Grade III splenic laceration, and a Grade II liver laceration. Treatment of these injuries included distal pancreatectomy and splenectomy. Hemostasis of the liver laceration was accomplished with gelfoam, thrombin and electrocautery. The open left supracondylar humerus fracture was treated with open reduction and internal fixation.

Postoperative complications included a left subphrenic abscess which required open drainage. This patient was discharged after a prolonged hospital course.

Third case report

A 52-year-old female was an unrestrained driver in a high speed, single motor vehicle accident. Extensive vehicle damage was noted, including marked deformity of the steering wheel. The patient suffered a brief loss of consciousness and was trapped for 20 minutes. Initial vital signs were blood pressure 80/0 and pulse was 130 beats/min. Mast trousers were applied, crystalloid fluid resuscitation begun, and she was brought to Ruby Memorial Hospital.

On arrival, this patient's blood pressure was 130/90 and the pulse was 112 beats/min. Initial evaluation revealed a left flail chest and a soft, non-tender abdomen. Significant laboratory data included a hemoglobin of 12.1 mg./dl. and a serum amylase of 301 units/dl. Chest roentgenogram revealed a widened mediastinum. CT scan of the abdomen and pelvis demonstrated an irregularity of the head of the pancreas (Figure 6).

Aortography was performed which revealed a transected descending thoracic aorta. She was taken to the operating room for aortic repair and repair of an unsuspected diaphragm rupture. Following surgery, she required blood transfusions. A repeat

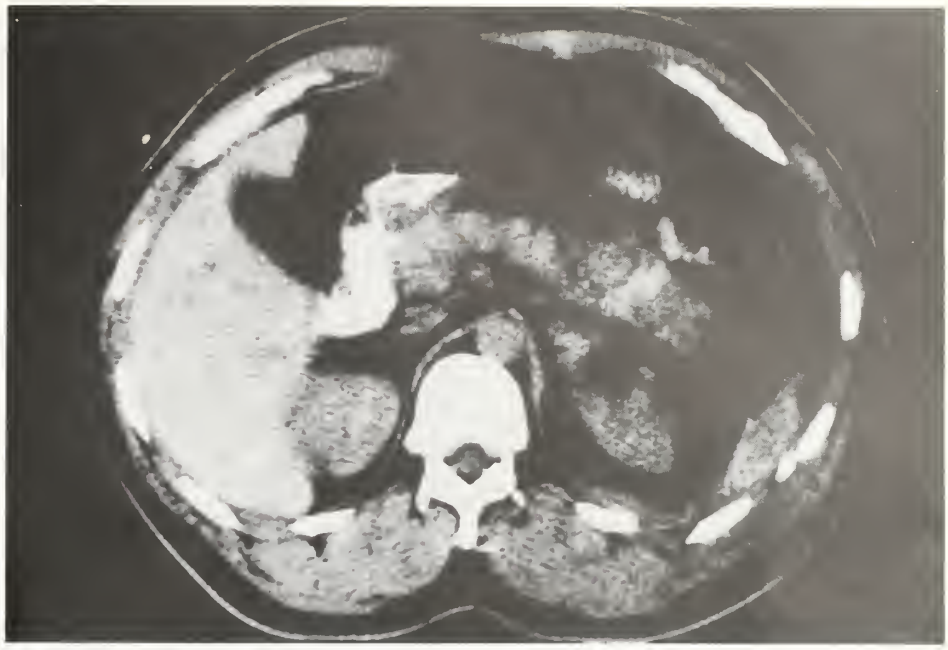

Figure 2. Case 1 – CT scan revealing transection of the body of the pancreas.

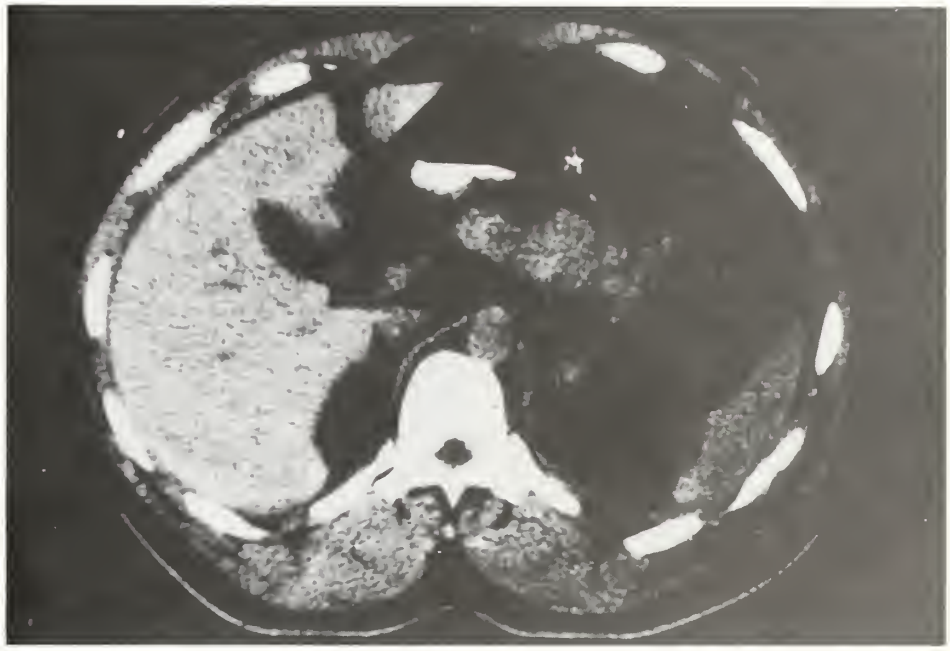

Figure 3. Case 1 – CT scan showing pancreatic edema, loss of pancreatic contour and pancreatic fracture.

serum amylase was 777 units/dl. Repeat abdominal and pelvis CT scan demonstrated a pancreatic transection, large retroperitoneal hematoma, and free intra-peritoneal fluid (Figure 7).

She was returned to the operating room where a severed portal vein injury and pancreatic transection were found. Because of hemodynamic instability, portal vein venorrhaphy and drainage of the pancreatic bed was performed and the patient was returned to the Surgical ICU for further stabilization. Subsequently, she was brought to the operating room multiple times for pancreatic debridement. She was discharged after a prolonged hospital course.

Discussion

Due to the potentially severe complications of blunt pancreatic injuries, attempts have been made to allow quicker and easier pre-operative diagnosis. Expeditious diagnosis and early operative intervention are desirable for several reasons.

Early (< 48 hours post-injury) morbidity and mortality is generally due to associated injuries which are present in 60%-80% of cases (1,2,3,4). Delays in diagnosis can lead to excessive late (> 48 hours post-injury) morbidity and mortality related to the pancreatic injuries alone (5).

Another problem with delayed diagnosis is that there is an increased chance of complications such as fistulas, abscesses, secondary hemorrhage, pseudocysts and pancreatitis (4). In fact, a pseudocyst can develop as early as six days post-injury if a significant pancreatic injury is missed (6). In addition, pancreatic injury may lead to the exudation of pancreatic juices into nearby tissues which leads to severe inflammatory changes, so delays in diagnosis lead to technically difficult operations.

Numerous diagnostic modalities exist for the evaluation of pancreatic injury. Physical examinations often reveal only subtle abdominal findings. There may be initial epigastric or diffuse abdominal pain which is followed by transient diminution of symptoms for one to two hours (5,7). This temporary decrease in pain may give the examiner a false sense of security and increase the chance of a delayed or missed diagnosis of pancreatic injury (5,7). Furthermore, even patients with complete pancreatic duct transection may be asymptomatic for several weeks after injury (4). This lack of symptoms is attributable, in part, to the initial confinement of the pancreatic injury to the retroperitoneum (5).

Figure 4. Case 2 – CT scan showing fluid in the lesser sac, free abdominal fluid and pancreatic edema.

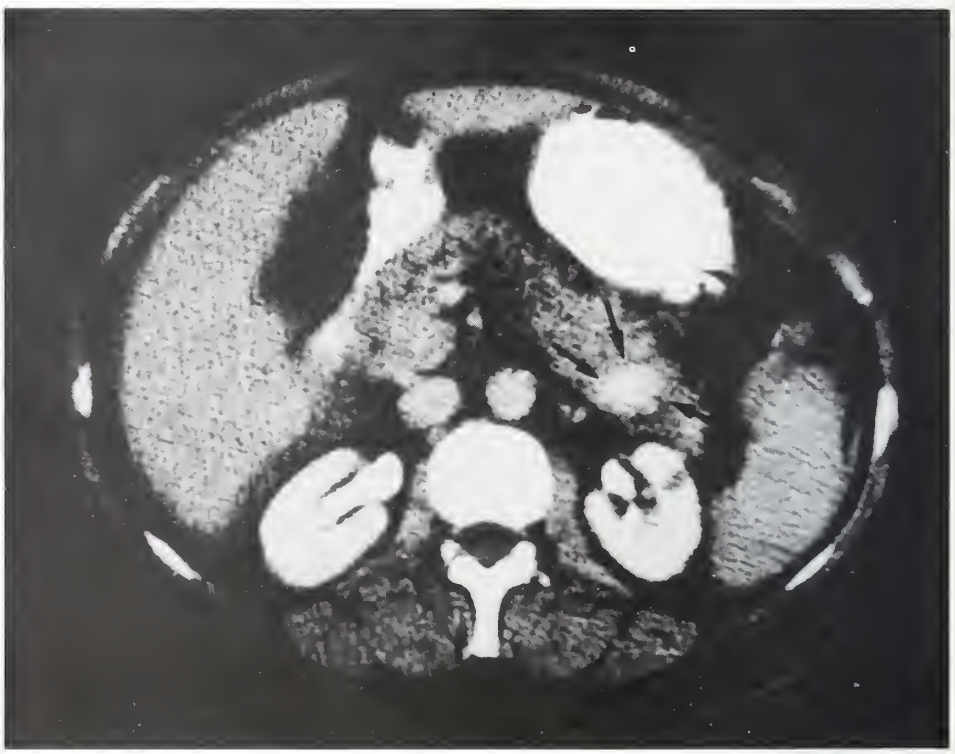

Figure 5. Case 2 – CT scan demonstrating pancreatic edema, loss of pancreas contour, and contusion injury in the tail of the pancreas.

Associated injuries may distract the patient and the examiner from the usually non-specific abdominal findings of pancreatic injury. Inactivation of pancreatic enzymes and glandular secretory inhibition occurs after pancreatic trauma which results in further delays in diagnosis (4). Obviously, a high index of suspicion is mandatory for proceeding with

further diagnostic evaluation of pancreatic trauma.

The serum amylase level has been a controversial diagnostic study in assessing pancreatic injury. Many physicians believe the amylase level is a non-specific and unreliable indicator of pancreatic injury (7,8,9,10). The serum amylase may be elevated in only 48% of patients with pancreatic trauma (6). In addition, the degree of serum amylase elevation does not correlate with the degree of injury (1). More importantly, even with total disruption of the pancreatic ductal system, the serum amylase may not be elevated until 24-48 hours post-injury (1). This delayed rise in the serum amylase forms the basis for serial serum amylase determinations. In addition, a persistent elevation of serum amylase is a stronger indication of pancreatic injury than an isolated value (4). This point is exemplified in the patient described in the third case.

Plain abdominal roentgenograms are usually performed in stable trauma patients suspected of having intra-abdominal injuries. However, plain radiographs are frequently non-specific and unrewarding in diagnosing pancreatic injury (11). Significant findings are present in only 18% of cases (7). This lack of diagnostic specificity is not improved with the use of oral contrast agents. Diagnostic peritoneal lavage lacks sensitivity for pancreatic injury and may even be normal in patients with ductal injury (5,7,9).

CT scan has emerged as the superior diagnostic modality in pancreatic trauma. This is due, in part, to the fact that blunt trauma evaluation remains the most common indication for initial CT scan (2). The CT scan has been regarded as the best method for diagnosing pancreatic fracture in adults (12), but CT scan diagnosis of pancreatic injuries in children may be more difficult because of their low amount of retroperitoneal fat which diminishes the contrast between structures (13). Of utmost importance in the selection of patients as candidates for CT scan for diagnosing pancreatic injury is hemodynamic stability (8). Another important feature of CT scanning is that the sensitivity and specificity can exceed 80%, but is dependent on the interpreter and the quality of the scanner (3).

Numerous CT scan findings are suggestive of pancreatic injury (Table 1). Traumatic pancreatitis results in gland swelling with inflammatory changes in the peripancreatic fat and mesentery

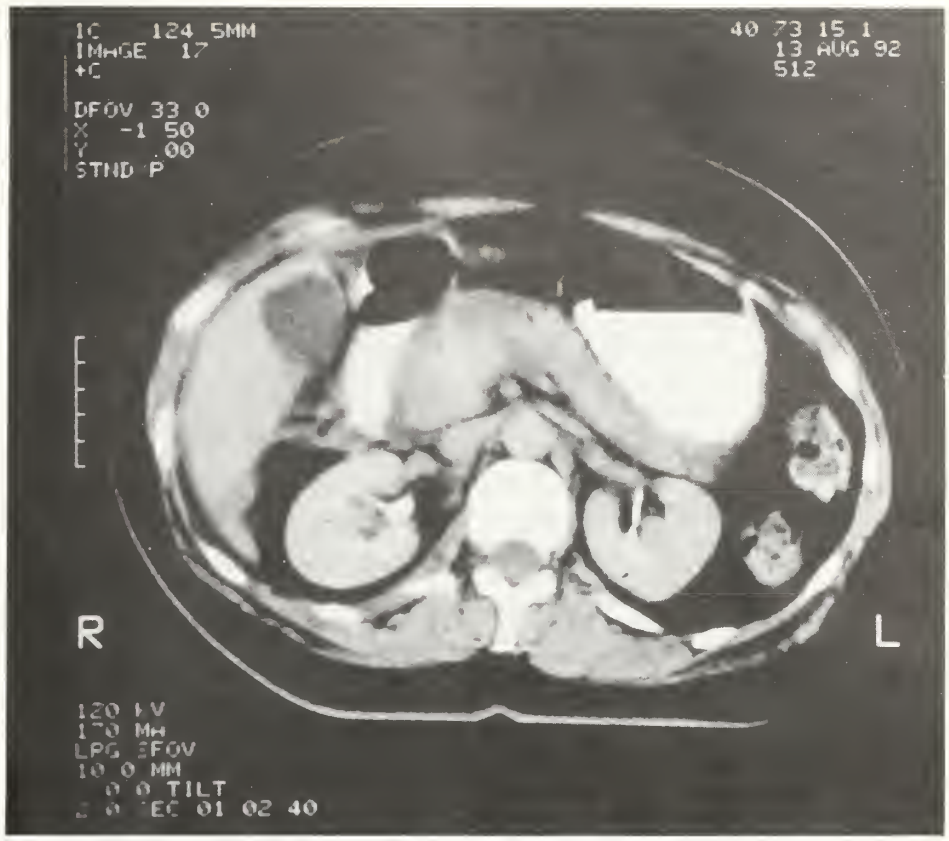

Figure 6. Case 3 – CT scan showing edema of the head of the pancreas.

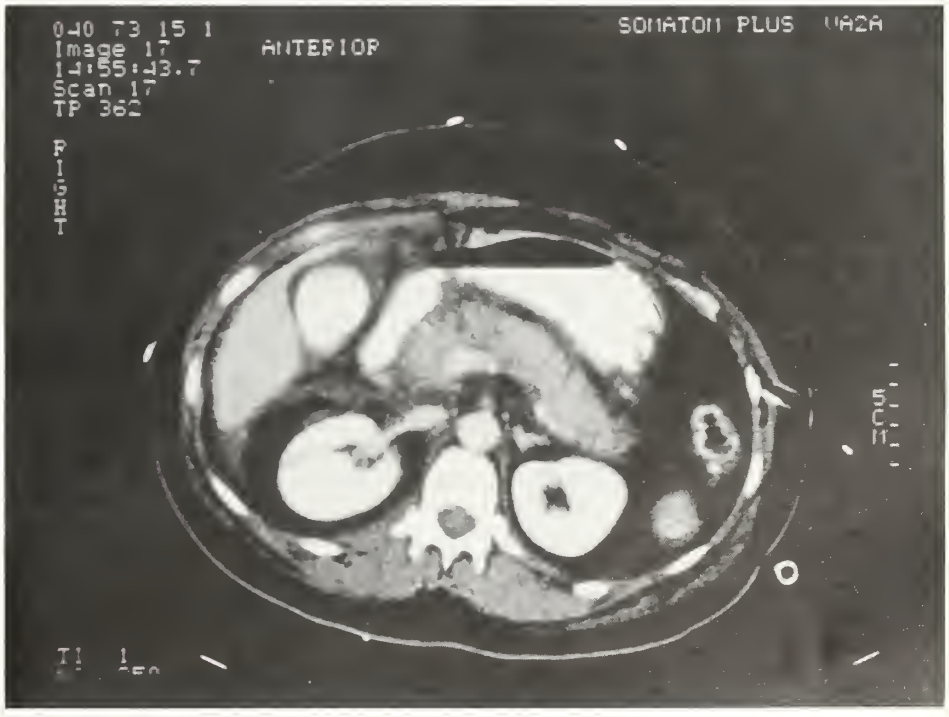

Figure 7. Case 3 – CT scan showing transection through the neck of the pancreas.

(2,4,11). Other findings include obliteration of the pancreatic contour, thickening of Gerota's fascia, and exudation of fluid into the anterior and/or posterior pararenal space and lesser sac (8,13,14). There may also be hemorrhage into the peripancreatic fat, mesocolon and mesentery (2). Thickening of the left anterior perirenal fascia is seen in the majority of cases of fracture of the pancreas secondary to blunt trauma (12). Several

of these characteristic CT findings were found in each of our three patients.

There are disadvantages to CT scanning in diagnosing pancreatic injuries (8,15). False positive scans are often due to a vertical, low density plane through the neck of the pancreas (2). This plane results from fat around mesenteric vessels, physiologic thinning of the pancreatic neck, and unopacified proximal bowel (2). False positive scans can also result from "streak" artifacts (12). False negative scans in patients with pancreatic fracture can be a result of observer error, too little contrast medium, hematoma obscuring the fracture, or close apposition of fracture margins which "spring" back together (12).

Another disadvantage is that very early (< 12 hours) CT scan findings may be minimal (2), and the scan may initially be interpreted as normal in 40% of cases (7,15). Major pancreatic ductal injury can occur without obvious changes on initial CT scan (15). Thus, stable patients in whom a high index of suspicion exists should have repeat CT scans in 12-24 hours (2,8). Improvements in diagnosis may be made with dynamic CT scanning (2,12) and scanning at 5 mm. slices (instead of the standard 1.0 cm.) (12).

Endoscopic retrograde cholangiopancreatography (ERCP) can play a significant role in diagnosing pancreatic injuries in the hemodynamically stable patient (1). ERCP may supplement or confirm the diagnosis, particularly in patients with late (> 48 hours) diagnosis of pancreatic injury (2,7). ERCP is recommended in stable patients without peritoneal signs and with a rising serum amylase to document the presence of major pancreatic ductal injury (9). Ultrasound examinations are generally felt to be of little benefit in the early diagnosis of acute pancreatic injury.

Conclusions

The diagnosis of pancreatic injury due to blunt trauma remains a challenge for the clinician. Among the various tools to diagnose pancreatic injury, CT scanning has proven to be quite beneficial. An interval CT scan with close observation of the stable patient with equivocal findings is frequently useful.

Despite the diagnostic value of CT scanning in pancreatic injury, interpretation of the scan is an inherent limitation. A high index of suspicion combined with characteristic CT scan and physical findings can afford expeditious assessment and management of this injury.

Table 1. CT Signs of Pancreatic Injury

1. Pancreatic edema and loss of contour lines
2. Inflammatory changes in peripancreatic fat and mesentery
3. Thickening of Gerota's fascia
4. Exudation of fluid into anterior and posterior pararenal spaces, and lesser sac
5. Hemorrhage into peripancreatic fat, mesocolon, and mesentery
6. Pseudocyst formation

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Injury in West Virginia: An introduction to injury control and prevention

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Abstract

Each year, one of every four Americans sustains an injury severe enough to seek medical attention. Injuries account for 25% of all emergency department visits, 12% of all hospital admissions, and cost the nation over $180 billion annually (1). Despite being the leading cause of mortality for Americans under the age of 40, there is a lack of awareness of the epidemic of injuries and effective methods for their prevention. Many consider injuries to be the result of unavoidable accidents or unfortunate acts of God. In reality, injuries are diseases which have associated risk factors, demographic distributions, seasonal variations, epidemic episodes, and are predictable and preventable. This article describes injuries in West Virginia and discusses basic principles of injury control and prevention.

Introduction

Injuries are the third leading cause of all deaths in the United States and West Virginia. However, injuries are by far the major cause of deaths among children and young to middle-aged adults (1). In fact, for ages one through 44, injuries surpass both cancer and heart disease as causes of death (1) (Figure 1).

Since deaths due to injury occur disproportionately in the young, comparing the total number of injury deaths with deaths from other causes fails to take into account the years of potential life lost. It is important to consider how the deaths of so many young people affect the future. What might they have contributed? The effect of this premature mortality is reflected in the measurement of years of potential life lost (YPLL) in each age group before 65 years. Figure 2 shows that injuries are responsible for more years of potential life lost than cancer and cardiovascular disease combined (2).

West Virginia's death rate

The risk of injury is higher in rural areas, such as West Virginia, and among economically disadvantaged populations (3). In fact, West Virginia's injury fatality rate is greater than the U.S. rate for all ages and nearly all types of injury. Nationally, the injury-related death rate is 62.1 deaths per 100,000 population (all ages); and in West Virginia, that rate is 69.5 per 100,000 population, which is 13 percent above the U.S. rate (Figure 3)(1).

The fatal injury rate for young adults ages 25 to 44 in West Virginia exceeds the nation's rate by 18 percent, and the motor vehicle traffic fatality rate for this age group in West Virginia surpasses the national figure by 50 percent (4)(Figure 4). In 1992, 29,000 West Virginians experienced a motor vehicle-related injury severe enough to require medical attention (3). This may be attributable to poor road conditions and the transportation hazards associated with West Virginia's occupational environments. Other factors which may account for a higher motor vehicle injury rate include the lack of seatbelt legislation until September 1993 and the sanctioning of a 65 MPH highway speed limit.

The death rate due to fire and burn injuries in West Virginia is 30 percent above the U.S. rate (Figure 3)(4). One study hypothesized that these deaths are largely due to house fires resulting from the use of hazardous home heating systems such as wood stoves, fireplaces, and space heaters. Over 2,700 individuals in West Virginia were medically treated for burns during 1992 (3). Many of these injuries and deaths could have been prevented by strategies such as installation of smoke detectors, inspection of home electrical wiring, and planned escape routes.

The injury process

Injury is defined as any damage to the human body resulting from acute exposure to physical energy, or from the absence of vital entities such as heat and oxygen. The five forms of injurious energy are thermal, mechanical, electrical, radiating and chemical. Roughly three-fourths of all injuries are caused by exposure to mechanical or kinetic energy during incidents such as motor vehicle crashes, falls, and firearm discharges. Examples of injury resulting from a lack of heat or oxygen are hypothermia and asphyxiation, respectively.

Epidemiologically, injury may be defined as a disease resulting from the interaction of the following three forces, *host*, *agent* and *environment* (Figure 5). As illustrated in Table 1, an analogy has been made between the behavior of injury and the classic infectious diseases such as malaria (1). In the case of injury, the host refers to the victim, the agent is the energy involved, and the environment is that which provides the opportunity for the agent (energy) to impact the host. The environment may be either protective and prevent injury, or unsafe and promote injury. The vector refers to the mode by which energy is transferred to the victim or host. For example, during a motor vehicle crash, the automobile is the vector which transmits physical (kinetic) energy to the host, or driver.

Injury results when the victim is exposed to energy that exceeds human tolerance. In most cases, energy is transmitted as the victim attempts a specific task or action. The *task performance* refers to how well one executes an action (such as driving a car) and the *task demand* is the skill required to successfully perform the task (such as maneuver a curve on an icy road while driving).

When performance is below the

Table 1. An Etiologic Comparison of Injury and a Classic Infectious Disease

DISEASE	HOST	AGENT	VECTOR/VEHICLE	EXPOSURE EVENT
Malaria	Human	P. Vivax	Mosquito	Mosquito bite
Injury (Head injury, for example)	Human	Kinetic energy	Motor vehicle	Crash

task demand for the action, uncontrolled energy is released and may lead to injury. For example, a drunk driver may lack the skills necessary to drive his or her car along a curve in the road. The resulting crash provides the opportunity for kinetic energy to impact the driver and may result in injury. However, if the environment is protective, with automobile airbags and seatbelts, or the road is equipped with guard rails, injury can be prevented or the severity of the injury may be reduced (Figure 6).

Analyzing an injury

Any injury event can be separated into three phases: pre-injury, injury, and post-injury. For each phase, host, vehicle, and environment factors play a part in the injury event. Pre-injury factors are those that contribute to or inhibit the release of the injurious energy. During the injury phase, certain factors can affect transmission of energy to the host. Components of the post-injury phase impact the severity and outcome of injury after the injury event has occurred.

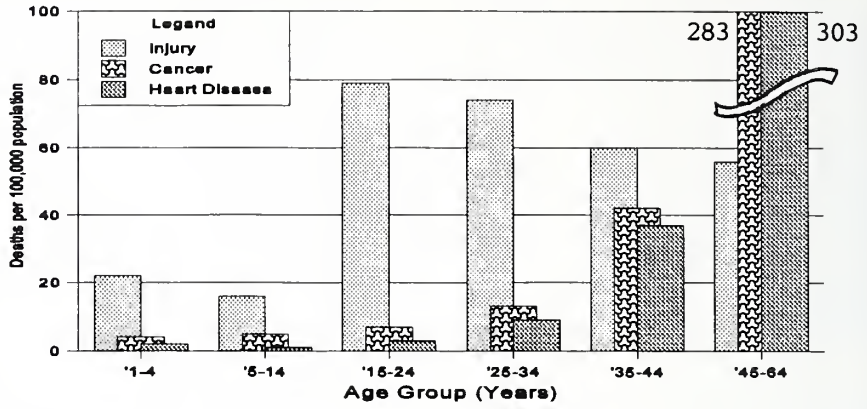
Haddon's matrix is a tool used for injury analysis that incorporates the different factors for each phase of the injury event. Analyzing an injury using Haddon's matrix is a practical way to identify factors that affect the injury and show that injuries are the result of a multitude of causal factors which occur during various phases of an injury event. A Haddon's matrix analysis of a motor vehicle crash is illustrated in Figure 7.

Principles of prevention

The aim of injury prevention is to avert or reduce injury by modifying transmission of energy to the individual. Prevention strategies such as wearing a seatbelt, using motorcycle and bicycle helmets, and installing smoke detectors have been shown to reduce injury morbidity and mortality.

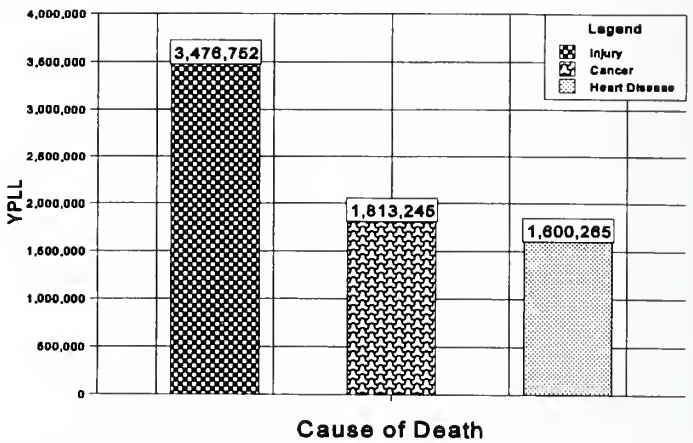
To describe the incidence, demographic distribution, and the cause and risk factors of injuries, an injury surveillance system is utilized. The ability to adequately identify problem injuries and high-risk groups is dependent on the quality of data collected. Injury surveillance forms the foundation of injury control and is necessary to formulate and target effective prevention strategies. A basic component of injury surveillance is the "E-code," and E-coding is a standardized method of categorizing external causes of injury in terms of how and where the injury occurred.

Figure 1. Death Rates by Cause and Age



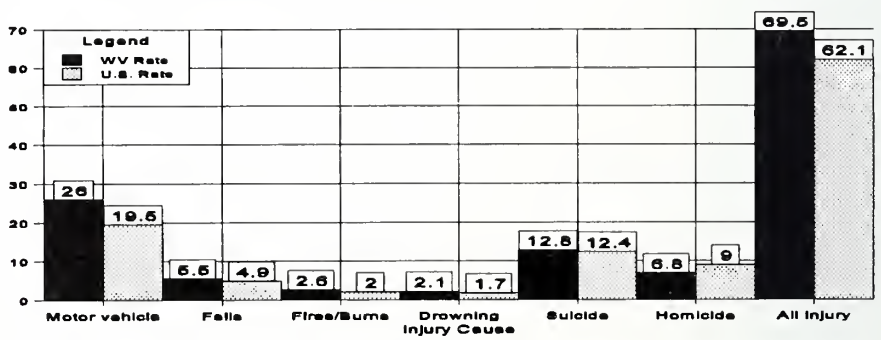
Adapted from Baker SP, O'Neill B, Ginsburg MJ, and Li, G, The Injury Fact Book, 1986 statistics, Oxford University Press, 1992.

Figure 2. Causes of Death and YPLL



Adapted from "Injury Prevention: Meeting the Challenge," Centers for Disease Control, 1985 statistics.

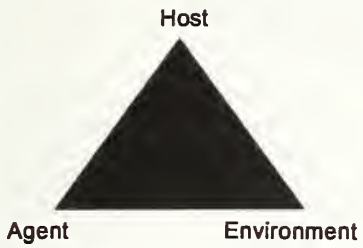
Figure 3. Fatal Injury in WV and U.S. (All Ages)



All rates are calculated per 100,000 population. West Virginia denominator = 1,824,710. U.S. denominator = 245,807,000.

Adapted from "A Comparison of Injury Mortality Rates," WV Dept. of Health and Human Resources, September 1992.

Figure 5. The Injury Epidemiology Triangle



Although E-codes are vital in injury prevention, their use in hospital discharge and billing is mandated in only 14 states.

Currently, E-coding is only performed on a voluntary basis at a small number of hospitals in West Virginia, so it is nearly impossible to determine causes or circumstances for the majority of injuries. Data on etiology of injury obtained via E-codes is essential for designing prevention strategies and evaluating their effectiveness. A movement toward mandatory E-coding at hospitals in West Virginia was initiated by the WVU Center for Rural Emergency Medicine in 1993, but further advocacy is dramatically needed so E-coding is made mandatory at all hospitals in the state.

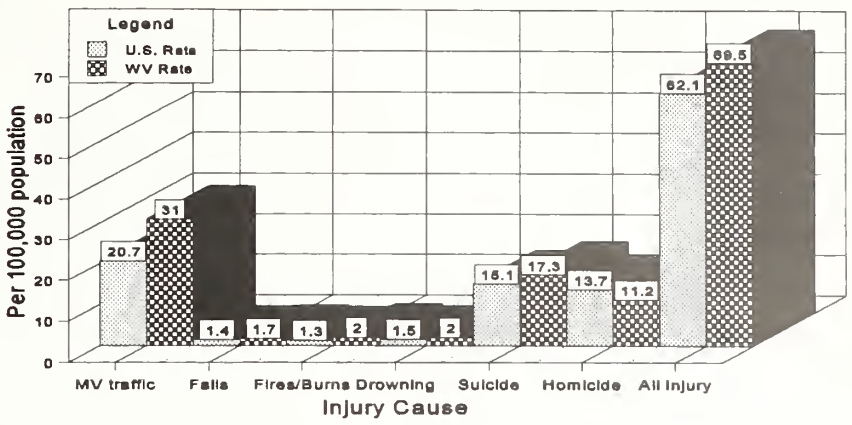
Interventions

Haddon's matrix may be used to identify factors affecting injury, and many of these factors can be modified by either educational, enforcement and engineering interventions which are aimed at reducing the incidence and/or severity of injuries.

Interventions may also be classified as active or passive. Education and enforcement are examples of active interventions since they require people to change their behavior in order to be protected. Examples include educational programs on child safety or laws mandating seatbelt use. Unfortunately, these efforts are often ignored by those at highest risk of injury, such as lower socioeconomic populations.

Passive interventions provide automatic protection and are generally more effective than active interventions since they do not rely on change in human behavior. Modifications in engineering and design of vehicles, such as airbags and softer dashboards, are examples of passive interventions that have been effective in reducing the incidence and severity of motor vehicle-related injuries.

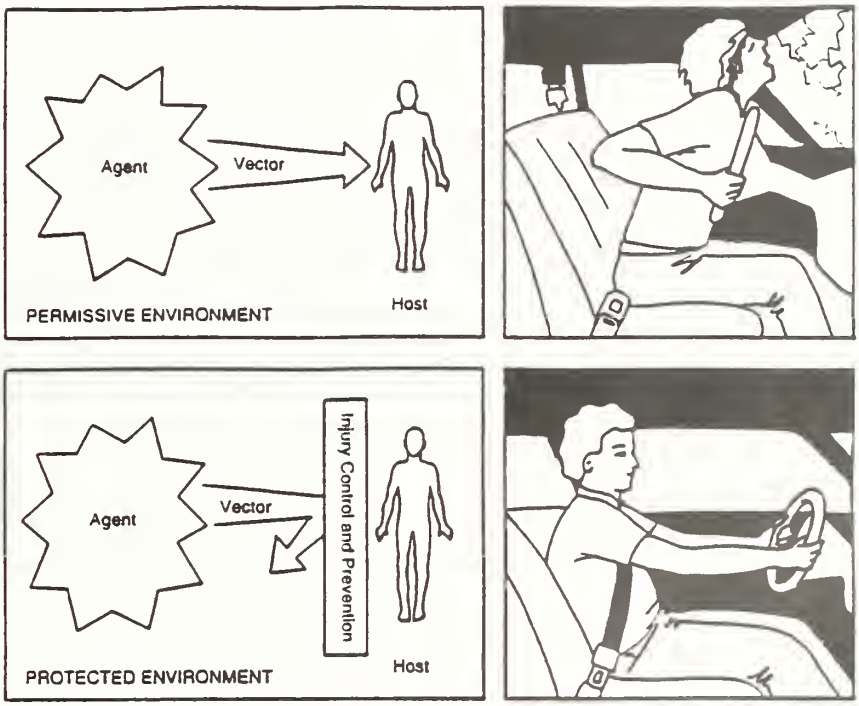
Figure 4. Fatal Injury in WV and U.S. Ages 25-44



All rates are calculated per 100,000 population. West Virginia denominator = 528,850. U.S. denominator = 78,939,000.

Adapted from "A Comparison of Injury Mortality Rates," WV Dept. of Health and Human Resources, September 1992.

Figure 6. Permissive vs. Protected Environments



When developing injury prevention programs, the following suggestions can increase your chances of being successful:

1. Target efforts toward a problem which occurs frequently or results in severe injury in your community. In some regions, this may be house fires and for others, motor vehicle crashes.
2. Address problem injuries that have specific, effective countermeasures. Focus on limited, concrete solutions to specific injuries and avoid diffuse, general approaches. Examples of specific solutions include smoke detectors for preventing house fires and helmets for preventing bicycle-related head injuries.

3. Make the intervention as simple as possible to increase public acceptance and minimize misuse.
4. Develop a critical mass of community awareness through broad-based grass roots support, legislation, enforcement, and professional action. Utilize affiliations with community leaders to build injury prevention coalitions.
5. Promote institutionalization of programs to last beyond the initial volunteer effort or temporary grant funding. Injury prevention programs need to be permanent fixtures.

The scope of injury prevention and control extends far beyond surveillance and prevention of injury, and includes acute care and rehabilitation of injured patients. Acute care begins in the field during prehospital resuscitation and continues as the patient is treated in the emergency department, operating room, and hospital system. The goals of acute care are to reduce the morbidity and mortality of injured patients and to maximize the patient's physical, social and mental function.

Rehabilitation begins during acute care and continues until the patient's level of function is maximized -- ideally to pre-injury level. Depending on the type and severity of injury, physical therapy or psychiatric care may be required. Rehabilitative support may extend beyond the hospital phase and into the home with household adjustments such as wheelchair ramps or widened doorways to allow easier access for those dependent on wheelchairs.

The medical professional's role

There are seven ways that medical professionals can utilize their knowledge and influence to help prevent injuries in their communities and reduce the severity of injuries that do occur:

1. **Treat acutely injured patients.** Prompt recognition and care of the primary injury and all related injuries is important to minimize further damage.
2. **Recognize injury as a community-wide problem.** When a potentially hazardous condition exists, the community as a whole is at risk. Since injuries are more prevalent among the young, the community suffers tremendous emotional trauma and bears the cost of lost productivity, medical care, long-term rehabilitation, legal actions, and lost tax revenue.

Figure 7. Haddon's Matrix

Haddon's Matrix

Phases	Factors: Host	Vehicle	Physical Environment	Sociocultural Environment
Pre-event	Impaired capacity due to sicohol, sge, poor vision, fatigue, lnexperience, poor judgment	Defective parts (brakes, tires) Poor maintenance, dirty windshield/ windows, improper brake lights, ease of control, speed of travel	Narrow road shoulder, poor lighting, road curvature and gredient, road surfsce type, weather conditions, divided highway, visibility of hazards, signalization	Attitudes sbout alcohol, drunk driving laws, speed llmits, injury prevention programs.
Event	Tolerance of body to energy, injury threshold due to sging, chronic dlsease (osteo-porosia), etc. Ssfety belt use	Placement hardness and sharpness of contact surfaces (dssh, steering wheel), automatic reatraints, vehicle aize	Recovery sress, gusrd rails, fixed objects (telephone poles, trees), median barriers, embankments	Attitudes sbout sestbelt use, enforcement of child safety sest lswa
Post-event	Extent of lnjury sustained, knowledge of first sid, phyaical condition end age	Fuel system integrity (bursting gaa tank), entrapment of victim	Access to EMS, quality of EMS csre, avsilablity of extrication equipment, rehabilitation programs	Training of EMS personnel, trauma system programs
Results	Physicel and mental impairment	Cost of vehicle repsir	Damage to environment	Legal coats, costs to society (loss of lives snd income)

3. **Incorporate injury control into your everyday practice.** By recognizing injury as a disease, medical professionals should seek to identify individuals at high risk for injury, evaluate the patient's risk factors, and develop effective strategies. For example, a child who is being treated for a cold who lives in a home with a swimming pool is at risk for drowning and other pool-related injuries. Practical prevention plans include counseling parents on the importance of swimming lessons, referral to community swimming programs, and information on use of pool covers, fencing, and water motion alarms.
4. **Counsel injured patients on controlling injury in the future.** No injured patient or his or her family should leave a health care facility without a better understanding of how the injury could have been prevented. We, as health care providers, have a responsibility to counsel our patients on how to modify risk factors for future injury (alcohol abuse, lack of seatbelt use, etc.).
5. **Be a leader in injury control and educate your colleagues.** Injury control principles should be integrated into continuing medical education and prevalent in medical publications. Ample opportunity exists to educate colleagues on injury control.
6. **Identify new injury patterns in your community.** New injury patterns may occur that affect your community or possibly the nation. Medical professionals can help by identifying high-risk groups for these injuries and reporting cases to medical journals, local authorities or medical societies.
7. **Act as an injury control advocate in your community.** The medical professional's role in the community is unique and provides an opportunity to act as a credible, knowledgeable advocate for injury control through public speaking, letters to policymakers, legislative testimony, media contact, and helping to educate other professions. Support for implementation of E-codes at local hospitals is essential to injury control.

Conclusions

Injury is a serious problem facing our state and nation. Through concerted effort toward injury prevention, medical professionals can help improve the lives of West Virginians and make a positive impact on the economy of our state. By recognizing injury as a predictable and preventable disease process, like heart disease, health care providers should strive to identify those at risk of injury and determine appropriate countermeasures.

Injury data collection is essential to understand the causes of injury and to design prevention strategies. Reporting the external cause of injury (E-codes) by all hospitals is needed in order to provide accurate data for use in developing and evaluating practical countermeasures. The medical professional is in a unique position to actively support mandatory E-coding and to practice injury control principles on a daily basis.

For more information on injury control and prevention or about advocating E-coding, please contact the WVU Center for Rural Emergency Medicine at (304) 293-6682.

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Manuscript Guidelines

All scientific manuscripts should be submitted on an IBM compatible disc in Wordperfect 5.1 or in ASCII (generic). They must be prepared in accordance with *"Uniform Requirements for Manuscripts Submitted to Biomedical Journals."*

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All manuscripts should include:

1. Title page
2. An abstract of no more than 150 words
3. Text
4. Acknowledgements
5. References in parentheses numbered consecutively. No more than 25 references will be published free of charge.
6. Tables
7. Legends for illustrations

All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the concept.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing its most commonly known trade name.

Tables (tabular listings) and figures (photos, drawings and charts) should be numbered, and the point of reference in the text indicated in parentheses, i.e. (Table 1), (Figure 10). Photos must be unmounted glossy prints in a 5 in. x 7 in. format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be done in solid black on pure white.

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Neurologic deficits restored after elective posterior fossa decompression

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Abstract

Arnold Chiari malformation is a condition in which the contents of the posterior fossa are herniated below the level of the foramen magnum, and it occurs in three basic forms. Patients with this condition frequently have obstructive hydrocephalus which requires a ventriculo-peritoneal shunt. This article describes the case of a infant female patient with Arnold Chiari Type I, who suffered an episode of acute hydrocephalus and neurologic deterioration after ventriculo-peritoneal shunt malformation. A shunt revision did not reverse her neurologic deficits, so a posterior fossa decompression was performed which did improve her condition.

Introduction

Arnold Chiari malformation is a condition in which the contents of the posterior fossa are herniated below the level of the foramen magnum. These patients frequently have obstructive hydrocephalus which requires a ventriculo-peritoneal shunt.

There are three basic types of Arnold Chiari malformation, and Type I is characterized by caudal descent of the cerebellar tonsils (1). Type II includes descent of both cerebellar tonsils and the vermis below the foramen magnum. Type III malformation is uncommon and involves caudal displacement of the cerbellum and the brain stem into a higher cervical meningocele.

Approximately 5 percent of patients with Arnold Chiari malformation may spontaneously experience progressive neurologic deterioration (2). This article describes the case of a patient with Arnold Chiari Type I, who suffered an episode of acute hydrocephalus and neurologic deterioration secondary to ventriculo-peritoneal shunt malformation. A shunt revision did not reverse her neurologic deficits. Her condition improved only after a posterior fossa decompression was performed several weeks after the acute event.

Case report

The patient, a 12-month old female, had been noted to have a marked increase in her head circumference at one week of age. A CT of her head at that time showed hydrocephalus involving the lateral ventricles. A ventriculo-peritoneal shunt was put into place and she was discharged from the Neonatal Intensive Care Unit at Women and Children's Hospital in Charleston at three weeks of age. Her neurologic exam was normal and she was feeding without difficulties.

At eight months of age, this infant had been readmitted to the hospital with lethargy and vomiting. A CT scan showed bilateral hydrocephalus which was felt to be secondary to a malfunction of the shunt. She underwent revision of the shunt and did well postoperatively.

Four months later, she was again brought to the hospital and this time she was suffering from irritability and vomiting followed by a generalized seizure and apnea. After being stabilized, her shunt was tapped with an opening pressure of 53 cm./H20 (normal < 15). The cerebral spinal fluid was drained until the pressure dropped to 10 cm./H20. A revision of the shunt was performed within 24 hours. After surgery, her physical exam revealed significant quadriparesis, especially of the upper limbs. She was now drooling and her cough and gag reflexes were absent. The patient remained intubated with a naso-jejunal feeding tube in place to provide her with nutrition.

Three weeks after surgery, there was still no improvement in her neurological deficits. Tracheostomy, gastric tube placement and Nissen fundoplication were considered, and after her naso-jejunal feeding tube was removed, several studies were performed.

Barium swallow with video fluoroscopy showed ineffective sucking, laryngeal penetration with almost every swallow and abnormal emptying of the esophagus. A pH probe study showed a reflux frequency of 1.5 episodes/hr. (pH less than four 6.5 percent of the time). One episode was associated with bradycardia. A milk radioisotope scan, which was performed by placing the isotope and formula in the stomach by a nasogastric tube and then removing the nasogastric tube, showed two episodes of reflux in addition to some isotope activity in the lower area of the left lung demonstrated on late images. This being consistent with aspiration from a reflux episode. A fiberoptic laryngoscopy showed incomplete closure of the vocal cords and difficulty in handling secretions in the hypopharnyx. Electroglottography was consistent with severe vocal cord paralysis. Magnetic resonance imaging (MRI) showed findings consistent with Arnold Chiari Type I.

Twenty-five days after the ventriculo-peritoneal shunt revision, neurologic deficits remained unchanged. A posterior fossa decompression with dural patch widening graft placement and C1-C2 laminectomy was performed in an attempt to reverse her neurologic deficits. Within a period of one week, she was noted to have increased and more effective movement of her upper extremities. Her gag and cough reflexes also returned. The patient was extubated and was gradually able to resume oral feedings.

Thirty-three days after surgery, a repeat barium swallow with video-fluoroscopy and electroglottography showed normal results. The pH probe study showed no gastroesophageal reflux, and the milk scan did not show evidence of aspiration. At this patient's follow-up appointment when she was 15 months old, her neurological exam showed mild developmental delay without focal neurological deficits, and her brain stem function remained intact.

Discussion

Arnold Chiari Type I may be much more common in childhood than suspected. These patients may have a history of suspected SIDS, recurrent apnea, recurrent headaches, vomiting,

hydrocephalus, post-shunt procedures, inability to crawl or sit, neck pain, scoliosis, torticollis, weakness, ataxia, vertigo, dysphagia, dysarthria, incontinence, syncope, paresthesias, tinnitus and sudden death (3,4,5,6,7,8). Unfortunately, Arnold Chiari Type I is rarely considered a diagostic possibility for many of these symptoms.

Since MRI became widely available in 1985, the diagnosis of Arnold Chiari malformation has significantly increased. MRI is now considered the most reliable and least invasive method for imaging the brain stem (3,9). It is imperative that MRI is performed deep into the vertebral canal and not stopped at the foramen magnum. The radiologist and the technician should be informed that Chiari malformation is suspected.

The exact mechanism of Arnold Chiari malformation is not known. It has been postulated that it may result from a cranio-cervical growth collision (10) which displaces the posterior fossa structures in a caudal direction. This herniation may also be caused by pressure gradients between the cranium and the spine (11). There are a few described cases of familial origin, and patients with Arnold Chiari malformation may remain asymptomatic for their entire life or may develop symptoms as late as the sixth decade.

Approximately 5 percent of patients with Arnold Chiari malformation will develop progressive symptoms as a result of brain stem or cranial nerve dysfunction (1). Dysphagia has been found to be one of the most common brain stem dysfunctions in Arnold Chiari Type I and it usually precedes more severe abnormalities. The mechanism of the brain stem dysfunction is theoretically attributed to several factors including direct compression, endogenous dysgenesis, ischemia and adhesion formation secondary to continuous rubbing between the hind brain and the foramen magnum. Once a patient with known Arnold Chiari malformation becomes symptomatic, surgical suboccipital decompression should be considered, and in some cases an anterior transodontial decompression should precede the posterior decompression (4).

Dyste and colleagues reviewed 10 years of surgical experience with 50 patients suffering from symptomatic Arnold Chiari malformations. They found that after posterior decompression, 20 percent of the patients were asymptomatic, 66 percent improved, 8 percent stabilized, and in 6 percent the disease progressed in spite of the procedure (4).

Williams reported a series of 46 patients between 1980 and 1989 who underwent suboccipital craniotomy and cervical laminectomy for symptomatic Arnold Chiari. Of these patients, 15 presented with neurogenic dysphagia; four of the patients with mild dysphagia showed rapid improvement after surgery; and seven patients with more severe impairment (but with no other signs of severe brain stem compromise) also improved but more slowly. However, the outcome of the four patients who developed other severe brain stem dysfunction before surgery was poor (12). It was not stated whether these symptoms were precipitated by an acute episode of obstructive hydrocephalus.

Conclusions

Our patient had mild developmental delay without any focal neurological deficits before her last episode of ventriculo-peritoneal shunt malfunction, after which she developed severe brain stem dysfunction. This most likely resulted from a mechanical displacement and compression of the brain stem. Despite the ventriculo-peritoneal shunt revision and superior decompression, she remained symptomatic with a neurologic lesion which did not improve after three weeks.

We postulate that the acute hydrocephalus produced a mechanical displacement or impaction of part of the brain stem that superior decompression did not relieve. A posterior fossa decompression was performed with rapid and complete neurological recovery.

Thus, we feel that a child who presents with acute or progressing neurologic (especially brain stem) deficits and no obvious cause should be evaluated for a Chiari malformation. Significant morbidity may be relieved or avoided if surgical intervention is early.

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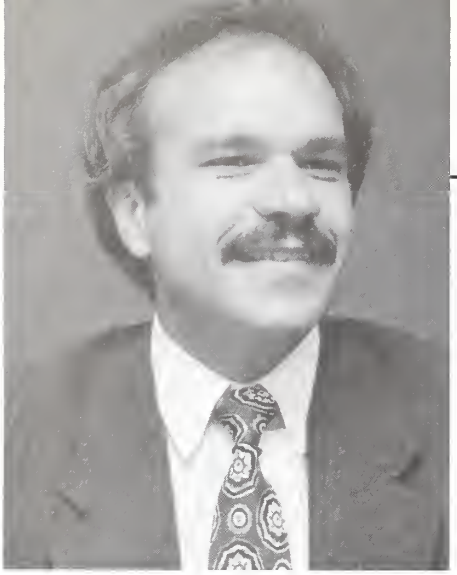

James L Comerci M.D.

Just say YES!

Recently, a call went out from President-Elect Denny Burton for requests for committee appointments to the standing committees of the WVSMA. This request reminded me of just how vital it is to have the proper physician input on our committees in order to keep the WVSMA a viable and strong organization.

The Executive Committee alone cannot possibly cover all the issues without feedback from committees. This has been one of the most frustrating experiences in the past year for me -- knowing that there is an issue which needs action, but not having the time to study it properly and formulate a plan. The committees who are the strongest and most successful are those that are the most active -- the Medical Education Committee, the Insurance Committee, the Legislative Committee, the Program Committee for the WVSMA Mid-Winter Clinical Conference and the Program Committee for the WVSMA Annual Meeting.

In order to have a strong committee structure, the WVSMA provides agendas, coordinates meeting dates, consolidates several meetings on the same days, and provides research and clerical support. Efficiency has also been achieved by regionalizing ad hoc committees to decrease travel time, and utilizing the mail and conference calls as an alternative to actual meetings.

A committee, though, is only as good as its leader and its members. A strong, active chairperson is vital to any committee's success so the members can concentrate on the broad issues; and the members must contribute their ideas and their time to help make the committee a productive one.

Since the committee structure of the WVSMA branches out from the Council and reports back this governing body, it is obvious that the success of committees is dependent on an active Council. In an attempt to increase attendance and help to strengthen the Council structure, a change in the bylaws will be introduced at the WVSMA Annual Meeting in August to allow for alternate councilors.

The bottom line is that I am asking those of you who are not currently active on one of our committees to join in and help make our committee structure more effective. Yes, I know that the distance to Charleston is a problem at times and that meetings are often not convenient, but isn't it better to be a part of the solution instead of the problem?

Too often, I hear critism from members who never participate on any of the WVSMA committees, or if they are members, never attend any of the meetings. If you have a specific interest or are concerned about an issue, get involved! Ask us to develop an ad hoc committee about a particular subject, agree to be a committee chair, assist us in building new committees, or help us maintain the ones that are already working well. Don't complain about the way the coach and the team are playing the game if you aren't even out on the field with them.

Just say YES when the call comes for you to participate on a committee!!!

James L. Comerci, M.D.

Truth in packaging

At an early July meeting of the Senate Finance Committee carried on C-SPAN, our own Senator Rockefeller asked for and was given the floor. The committee was busy "marking up" Senator Moynihan's compromise version of a health reform bill, one with which, from his later continued trumpeting of Hillary's original, Senator Rockefeller had to be displeased.

We are not sure that the senator's remarks were pertinent to or reflected any inclusion in the proposed or final version of the bill under discussion, but his remarks were interesting. He began discussing the need for work force or professional reform. His remarks seemed to be directed at the desirability of stripping medical schools and training centers in general of funds they currently receive for postgraduate training of residents.

According to Senator Rockefeller, these training centers are turning out "too many specialists." In developing his thesis, he stated that in this country today, "there are 80,000 too many specialists." From this point, he went on to calculate that since each of these specialists can be expected to generate $1 million in medical spending each year, a grand total of $80 billion in medical care each year is spent needlessly. His conclusion seemed to be that once "a balance" can be obtained between "generalists and specialists," which he indicated would be about a 50/50 mix, we can save gobs of money without affecting quality. He was thanked by the chairman and the committee went about its business.

Perhaps unneeded to be spoken is the need for someone, some committee, some board or some tribunal to manage and control a system such as the good senator proposes. The elements sound simple enough -- just allot enough training money for whatever general or specialty group seems to be in shortest supply. But what person, committee or group is smart enough or will have enough information to make such judgments? We seem to recall the Soviet Union having attempted to do similar things on an even grander scale in the recent past. Senator Rockefeller is no admirer of the Soviet system, but he should be able to learn from their failures.

A particular point of curiosity is an answer to the question. "What is to replace the yearly work output of those 80,000 specialists to be excluded from the system?" It is easy enough to envision a rationing system wherein there will be certain eligibility qualifications for any procedure or the use of any uncommon drug -- the British Health System is replete with such qualifications. Most specialists are involved with multiple diseases, conditions and age groups. To simply do away with any given number of specialists or randomly chosen field of specialty would thus ration and penalize members of all age groups and individuals with every known type of disease or medical condition.

Perhaps this is what our senator has in mind. With the years of study he professes to have devoted to medical care problems, West Virginians and the nation as a whole deserve better of him than this. If he believes rationing, draconian or otherwise, is necessary to keep the nation out of bankruptcy, he should be forthright enough to give his opinion out loud.

West Virginians who choose to listen to Senator Rockefeller's advice on medical care reform deserve to know the whole truth. They need to know the nature and the quality of the goods they are buying. We need a little truth in packaging on this issue from the senator.

Stephen D. Ward, M.D.
Editor

Letter to the Editor

PA program benefits health care in West Virginia

Adequate health care for many West Virginians is lacking or at best difficult to find, especially in rural areas. West Virginia ranks 48th in the nation in availability of health care, and 42 of West Virginia's 55 counties are designated as health professional shortage areas by the federal government. Physicians in many rural practices are often overworked and are unable to keep up with the demands for health care.

In the 1960s, physician assistant education was developed in the United States in order to train military corpsmen and medics for civilian practice. It has become a well-defined curriculum to train students as mid-level practitioners on the health care team, and is based on the following goals:

(1) To augment the capabilities of primary care physicians;

(2) To fill service gaps resulting from geographic and specialty maldistribution of physicians; and

(3) To help control health care costs (1).

Alderson-Broaddus College in Phillipi, W.Va., helped pioneer the education of PAs by admitting its first class in 1968, and being the first college to offer a bachelor of science degree in this profession. Alderson-Broaddus has graduated more than 700 PAs, and currently, 65% of all practicing PAs in West Virginia are graduates of Alderson-Broaddus College.

Over the years, PAs have found their way into a variety of practices. They function as physician extenders in both primary care and specialty practices. They offer primary care in many rural communities, and many work in hospital emergency departments and clinics. Unlike nurse practitioners and some other mid-level practitioners who practice independently, PAs practice directly with and under the supervision of physicians. They are team players.

In order to better respond to the state's health care needs, Alderson-Broaddus College is expanding its entering class size by 50 students through a cooperative program with the West Virginia University School of Medicine. In the last few years, master's degree programs were established in rural health care and emergency medicine. Alderson-Broaddus now offers the first master's degree program in the nation for physician assistants, and 40 students will be enrolled in these programs in the fall.

As physicians, we should be cognizant of the continuing contributions of Alderson-Broaddus College to health care in West Virginia. It is a dedicated member of our medical education team.

James L. Bryant, M.D., F.A.C.S.
Clarksburg

1. JAMA, April 27, 1994:1266-72.

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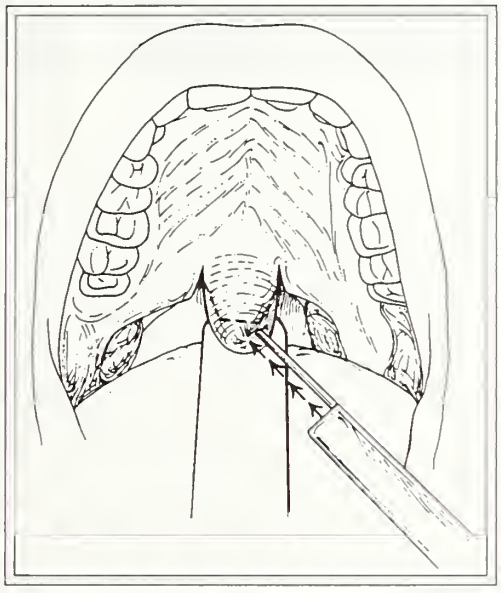

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At Alliance's Annual Meeting

AMAA, SMAA leaders to be keynote speakers

Barbara Tippins, president of the AMA Alliance, and Mildred Taylor, president of the SMA Auxiliary, will headline the program at the WVSMA Alliance's 70th Annual Meeting at The Greenbrier, August 19-20.

Mrs. Taylor will address the WVSMAA members on Friday, August 19 during the First Session of the House of Delegates, and Mrs. Tippins will speak on Saturday, August 20 during the Second Session of the House of Delegates. At the conclusion of the Second Session, Mrs. Tippins will install Sue Bryant of Bridgeport as president of the WVSMAA for 1994-95.

This year, the format for the meeting been shortened to two days, and WVSMAA President Carole Scaring will be presiding over all of the business meetings. Brief biographical information about Mrs. Tippins, Mrs. Taylor and Mrs. Bryant begins below, and additional details about the meeting can be obtained by contacting Winnie Morano, executive secretary of the WVSMAA, at (304) 925-0342.

Tippins

Taylor

Scaring

Bryant

AMAA, SMA leaders profiled

Mrs. Tippins, of Dunwoody, Ga., was installed as president of the AMA Alliance in June. She had previously served at the national level as field director; chairman and member of the Health Projects Committee; director; and as a member of the Nominating and Bylaws Committee.

In addition to serving in numerous positions for her state and county medical alliances, Mrs. Tippins has been president of both of these organizations. Most recently, she served on the Family Violence Committee for the DeKalb County Alliance, and as chairman of the Bylaws and Revision Committee for the Georgia Medical Alliance. The first Medical Association of Georgia Alliance member to chair a Medical Association of Georgia committee, Mrs. Tippins was chair of MAG's Adolescent Health Committee.

Mrs. Tippins has a bachelor of science degree in home economics from Georgia State College for Women. Prior to her marriage to William C. Tippins Jr., M.D., an obstetrician-gynecologist, she taught home economics and kindergarten. The Tippins have two children and Mrs. Tippins is also active in many volunteer and civic organizations.

Mrs. Taylor attended Chatham College in Pittsburgh and received a bachelor of science degree and a master's degree in speech pathology from Case Western Reserve University in Cleveland. After graduate school, she was an instructor in speech pathology, phonics and voice and diction at St. Louis University.

She married her husband, Charles, when he was in medical school at Washington University in St. Louis. They relocated from St. Louis to Portland, Maine, where she was active in the Junior League and with the United Cerebral Palsy Foundation assisting children and adults with language-related disabilities. The Taylors then moved to New Hampshire and during their years there she worked as a coordinator for special language programs for her school district, as a continuity instructor at the New Hampshire School for the Retarded, and as a speech pathology consultant.

The Taylors now reside in Columbia, Md., where Mrs. Taylor has been very active in both the state and her local medical auxiliaries. She also has been on the Executive Council of the SMA Auxiliary for over four years and has held many offices in this organization.

The Taylors have four children and four grandchildren. Mrs. Taylor is a member of the Alexandria Choral Society, which has performed in several countries abroad.

(Continued on page 294)

WVSMA Alliance Annual Meeting Highlights

Friday, August 19

10 a.m.	Pre-Convention Board Meeting
12:30 p.m. - 1:30 p.m.	President's Luncheon
2 p.m.	WVSMAA House of Delegates First Session
6:30 p.m. - 7:30 p.m.	Reception hosted by CNA/Acordia of West Virginia
9 p.m.	Entertainment - "Good Time Jazz Band" and Pat Leimbach, humorist

Saturday, August 20

8 a.m.	Past Presidents' Breakfast
9:30 a.m.	WVSMAA House of Delegates Second Session Installation of 1994-95 WVSMA Alliance Officers
12:30 p.m.	Post Convention Board Luncheon
2 p.m.	Golf and Tennis Tournaments

WVSMA Annual Meeting Highlights

Tuesday, August 16

6 p.m.	WVSMA Executive Committee Meeting

Wednesday, August 17

8 a.m.	WVSMA Executive Committee Meeting
11:30 a.m. - 1:30 p.m.	Executive Committee/Council Luncheon
1:30 p.m. - 4:30 p.m.	WVSMA Council Meeting
6:30 p.m. - 7:30 p.m.	Presidential Reception, hosted by the P.I.E. Mutual Insurance Company

Thursday, August 18

8:30 a.m. - noon	**General Scientific Session** "Peripheral Vascular Disease – Prevention, Medical/Surgical Management and Rehabilitation" John D. Holloway, MD, Moderator William F. Ruschhaupt, MD, Cleveland Clinic; Jeffrey W. Olin, DO, Cleveland Clinic; Doug Phillips, MD, University of Virginia; and Peter Kim Nelson, MD, New York University Medical Center; Panelists
Noon - 1:30 p.m.	**Lunch and Learn** "Managed Care . . . Minimizing the Risks," Jan Woerth, Ph.D., and a panel of visiting dignitaries
1 p.m. - 5 p.m.	WV Section of the American College of Obstetrics & Gynecology
2 p.m.	Golf, Tennis and Volleyball Tournaments
4 p.m. - 5:50 p.m.	1995 Annual Program Committee Meeting
6:30 p.m. - 7:30 p.m.	Reception, hosted by CNA/Acordia of West Virginia

Friday, August 19

7:30 a.m.	**Breakfast Meetings** WVSMA Surgery Section Breakfast
8:00 a.m.	WVSMA Dermatological Society Business/Scientific Meeting
8:30 a.m.	**First Session of the WVSMA House of Delegates** Edmund B. Flink Address - Richard S. Lang, MD, MPH, FACP, Cleveland Clinic Thomas L. Harris Address - John J. Bergan, MD, FACS, HON, FRCS(ENG), University of California - San Diego Business Meeting Presidential Address - James L. Comerci, MD
10:30 a.m. - 4 p.m.	WVMI Board of Trustees' Meeting
Noon - 1:30 p.m.	WVSMA Cancer Committee - Business Luncheon
Noon - 1:30 p.m.	**Lunch and Learn** "The Shifting Winds of Quality Oversight," Harry S. Weeks Jr., MD; Mark K. Stephens, MD; and a panel of visiting dignitaries
Noon	**Specialty Meetings**
Noon - 2:00 p.m.	WV Chapter of American Academy of Pediatrics
Noon - 4:30 p.m.	WV Psychiatric Association - Luncheon
12:30 p.m. - 2 p.m.	WVSMA Publication Committee - Luncheon
1 p.m. - 5 p.m.	American College of Obstetrics & Gynecology WV Section
1 p.m. - 4 p.m.	WV Orthopedic Society
1:30 p.m.	WESPAC Board Meeting (immediately following Lunch and Learn)
1:30 p.m.	Resolutions Committee - Open Session
6 p.m. - 7 p.m.	Reception hosted by WVU/MU Schools of Medicine, WVU and MCV Alumni
9 p.m. - midnight	Entertainment - Dance to the music of "Good Time Jazz" and enjoy the wit of Author-Humorist Pat Leimbach (Informal attire) – Chesapeake Hall

Saturday, August 20

7:30 a.m.	**Breakfast Meetings**
7:30 a.m. - 8:30 a.m.	Ohio County Medical Society and representatives from the Northern Panhandle
7:30 a.m.	Kanawha County Medical Society
7:30 a.m.	Young Physician Section
7:30 a.m.	WV Radiological Society
8:00 a.m.	WV Dermatological Society
8:00 a.m.	Delegate Registration
8:30 a.m.	**Second Session of the WVSMA House of Delegates**
9:00 a.m.	AMA Presidential Address - Robert E. McAfee, President, American Medical Association
11:30 a.m. - 1:30 p.m.	WVSMA 50-Year Graduates, Past Presidents, Visiting State Presidents and Component/Speciality Society Presidents' Luncheon
1:30 p.m.	**Reconvene Second Session of the WVSMA House of Delegates (business continued)** Oath of Office and WVSMA Presidential Address - Dennis M. Burton, MD
4 p.m. - 5 p.m.	Reception honoring newly-installed officers of WVSMA and Alliance Hosted by Cabell County Medical Society

Noted vascular surgeon to speak at Surgery Section meeting

John J. Bergan, M.D., F.A.C.S., HON., F.R.C.S.(ENG.), a clinical professor of surgery at the University of California in San Diego is the featured lecturer for this year's WVSMA Surgery Section Breakfast Meeting on Friday, August 19 at 7:30 a.m. during the WVSMA's Annual Meeting at The Greenbrier.

The topic for Dr. Bergan's lecture will be *"Advances in Treatment of Varicosities and Telangiectasis."* Following the Surgery Section Breakfast Meeting at 10:45 a.m., Dr. Bergan will deliver the Thomas L. Harris Address, *"Current Management of Extracranial Cerebral Vascular Disease,"* during the First Session of the House of Delegates. Dr. Thomas H. Chang, chairman of the WVSMA Surgery Section, is encouraging all interested surgeons and physicians to attend both of these presentations.

Dr. Bergan received his medical degree from the Indiana University School of Medicine in 1954, where he also completed his internship. He was influenced by the vascular surgery of Dr. Harris Shumacker during his internship and decided to complete his residency at the Northwestern University Medical School under the guidance of Dr. Walter Maddock, one of the founders of the Society for Vascular Surgery. Upon finishing his residency in 1959, Dr. Bergan was appointed to the faculty of Northwestern University.

Early research interests in pancreatitis led Dr. Bergan to explorations of vascular injury in this condition and then to the study of intestinal ischemia. This area of research continued to be Dr. Bergan's major interest, but he also began studying renal transplantation, pancreatic transplantation, and liver preservation. As a result of his research activities, he was appointed chief of transplantation at Northwestern University Medical School in 1969, and director of the Organ Transplant Registry at the American College of Surgeons in 1970.

Bergan

Since 1973, Dr. Bergan has been devoting his time to vascular surgery exclusively, describing the selective portosystemic shunt, and developing the non-invasive laboratory at Northwestern University Medical School with Dr. Yao. His interests in innovations in presentation led to the breakfast sessions held annually at the meetings of the Society for Vascular Surgery and the International Society for Cardiovascular Surgery, North American Chapter. Dr. Bergan was also instrumental in the formation of the Midwestern Vascular Surgery Society and the American Venous Forum.

In 1989, Dr. Bergan was named to his current position as a clinical professor of surgery at the University of California at San Diego. That same year, he also assumed his other two current posts as a clinical professor of surgery at the Uniformed Services University of the Health Sciences in Washington, D.C., and as an academic consultant in vascular surgery at Balboa Naval Hospital in San Diego.

During his career, Dr. Bergan has received numerous honors, including being awarded the Rovsing Silver Medal of the Danish Surgical Society and honorary memberships in the Royal College of Surgeons in England, the Vascular Society of Great Britain and Ireland, and the Vascular Surgery Section of the Royal Australasian College of Surgeons. He is a past president of the Society for Vascular Surgery, the European-American Venous Symposium, the American Venous Forum, the International Association of Vascular Surgeons, the Chicago Surgical Society, and the Gulf Coast Vascular Society.

To make reservations to attend the WVSMA Surgery Section Breakfast Meeting, please contact Nancie Divvens at (304) 925-0342.

(Continued from page 292)

New president highlighted

Mrs. Bryant has a bachelor of science degree in education, math and music from West Virginia University. She has worked with children and young people in a variety of organizations, and in 1985 she was the recipient of the Concern for Kids Award, which is presented by the Bridgeport Junior Women's Club.

Very active in her church, Mrs. Bryant currently directs two children's musical drama programs each year, and is assistant director of the adult choir, a teacher for an adult Sunday School class, chairman of the board of Christian Education, and a member of the Executive Council. Mrs. Bryant is a member of the board of directors for Health Access, Inc., Clarksburg's free clinic, and has been an independent travel agent for the past three and a half years.

Mrs. Bryant is the wife of James L. Bryant, M.D., the junior councilor at large for the WVSMA. The Bryants are the parents of two daughters and two sons, and have five grandsons. Mrs. Bryant's hobbies include traveling, cooking, sewing, crocheting and participating in community theater.

Ohio State plans internal medicine conference

The Seventh Annual Update in Internal Medicine will be conducted in Columbus from September 10 - 13 by the Ohio State Department of Internal Medicine and the Center for CME at University Medical Center. This course will feature discussions by Ohio State faculty members about many areas of internal medicine.

The program meets the criteria for 31 hours in Category I of the Physicians Recognition Award of the AMA and the AAFP.

For details, phone 1-800-752-8606.

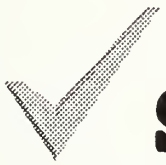
The West Virginia State Medical Association's

1994 Annual Meeting

August 17-20, 1994

The Greenbrier

White Sulphur Springs, West Virginia



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Please be sure to make hotel reservations in advance by calling 1-800-624-6070. **The Greenbrier will fill up quickly because the State Fair will be going on during the same week.**

Space is being held at other area hotels/motels, contact the WVSMA at 304-925-0342 for more details. For your convenience, you may call the WVSMA office and register for the conference using your Visa or Master Card.

1994 Annual Meeting

Name _____

Address _____

City _____ State ____ Zip Code ____

Specialty _____

Phone _____

Payment by: _ Check _ Visa _ MasterCard

Card Number _____

Expiration Date _____

Signature _____

Conference Cost:	WVSMA member	$125	___
	non-member	$175	___
Additional:			
Thursday, Aug. 18			
Learn and Learn	member/non-member	$ 40	___
(CME Credit)	spouse/student	$ 25	___
Friday, Aug. 19			
Lunch and Learn			
(CME Credit)	member/non-member	$ 40	___
	spouse/student	$ 25	___
	TOTAL:		___

If paying by check, please send registration form and check to:
West Virginia State Medical Association
P.O. Box 4106, Charleston, WV 25364

At the WVSMA's Annual Meeting

Lunch & Learn

"Managed Care . . . Minimizing the Risks"

Thursday, August 18 at Noon
in the Crystal Room at The Greenbrier

Featuring

Jan Woerth, Ph.D.
President of J.K. Woerth, Inc.

With Special Guest Panelists

Robert E. McAfee, M.D.
President of the American Medical Association

Donald H. Dembo, M.D.
President of the Medical & Chirurgical Faculty of the State of Maryland

Martin A. Murcek, M.D.
President of the Pennsylvania Medical Society

Claire V. Wolfe, M.D.
President of the Ohio State Medical Association

James A. Shield Jr., M.D.
President of the Medical Society of Virginia

CME Offered!!!

Name _____

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Phone _____ **CME Credit** _____

Member/Non-Member - $40 _____ **Spouse/Student - $25** _____

At the WVSMA's Annual Meeting

Lunch & Learn

"The Shifting Winds of Quality Oversight"

Friday, August 19 at Noon
in the Chesapeake Hall at The Greenbrier

Featuring

Harry S. Weeks Jr., M.D.
President and Director of the West Virginia Medical Institute

Mark K. Stephens, M.D.
Principal Clinical Coordinator for the West Virginia Medical Institute's Health Care Quality Improvement Program

With Special Guest Panelists

Robert E. McAfee, M.D.
President of the American Medical Association

Claire V. Wolfe, M.D.
President of the Ohio State Medical Association

Ardis D. Hoven, M.D.
President of the Kentucky Medical Association

Martin A. Murcek, M.D.
President of the Pennsylvania Medical Society

Donald H. Dembo, M.D.
President of the Medical & Chirurgical Faculty of the State of Maryland

James A. Shield Jr., M.D.
President of the Medical Society of Virginia

CME Offered!!!

Name _____

Address _____

_____

Phone _____ **CME Credit** _____

Member/Non-Member - $40 _____ **Spouse/Student - $25** _____

Continuing Medical Education

Listed on this page are some of the upcoming CME programs which will be held in the state. Unless otherwise noted, the events are presented at the location under which they appear.

If you would like to have the CME programs offered by your institution or association for physicians printed in the *Journal* or obtain more details about the meetings listed, please contact Nancy Hill, managing editor, at 925-0342.

Robert C. Byrd Health Sciences Center of WVU - Morgantown

August 18-20
"Total Joint Arthroplasty: Current Issues, Concepts and Considerations" (sponsored by the WVU Dept. of Orthopedics), Tamarron Resort, Durango, Colo.

August 27
"Managed Care in the 90s," The Marriott Marquis, New York, NY*

September 9
"Inaugural John E. Jones Symposium on Health Policy" (sponsored by the WVU Office of the Dean), Robert C. Byrd HSC of WVU, Morgantown

September 15-17
"20th Annual Hal Wanger Family Medicine Conference" (sponsored by the WVU Dept. of Family Medicine), Robert C. Byrd HSC of WVU, Morgantown*

September 23-24
"The 15th Annual Clinical Ophthalmology Conference" (sponsored by WVU Dept. of Ophthalmology and the WV Academy of Ophthalmology), Lakeview Resort and Conference Center, Morgantown

**Held in conjunction with a WVU football game*

West Virginia State Medical Association - Charleston

August 13
"Level One Loss Prevention," Beckley Hotel, Beckley

August 17-20
"WVSMA's 127th Annual Meeting," The Greenbrier, White Sulphur Springs

August 27
"Marbury vs. Madison," Radisson Hotel, Huntington

Outreach Programs

Key to Sponsors

★ *Robert C. Byrd Health Sciences Center of WVU, Morgantown*

☐ *CAMC/Robert C. Byrd Health Sciences Center of WVU, Charleston*

Beckley ☐ Beckley Hospital, Aug. 3, 6:15 p.m., "Medical Ethics," Warren Point, M.D.

Fairmont ★ Fairmont General Hospital, Aug. 2, 7:30 p.m. "Multiple Myeloma," Miklos Auber, M.D.

Fairmont ★ Fairmont Clinic, Aug. 17, 1 p.m., "Jaundice in the Newborn," Pam Quarantillo, M.D.

Gassaway ☐ Braxton County Memorial Hospital, Aug. 24, 6:30 p.m.*

Madison ☐ Boone Memorial Hospital, Aug. 9, 6:30 p.m., "Common Dermatosis," Donald Farmer, M.D.

Man ☐ Man Appalachian Regional Hospital, Aug. 17, 6:30 p.m., "Urinary Tract Infections in the Elderly," Lawrence Wyner, M.D.

Martinsburg ★ VA Medical Center, Sept. 1, 3 p.m., "Sleep Disorders," Robert Keefover, M.D.

Montgomery ☐ Montgomery General Hospital, Aug. 3, noon, "Parkinson's Disease," Albert Heck, M.D.

New Martinsville ★ Wetzel County Hospital, Aug. 11, noon, "Lymphoma," Paolo Romero, M.D.

★ Wetzel County Hospital, Sept. 8, noon, "Hepatitis," R. Wesley Farr, M.D.

Philippi ★ Broaddus Hospital, Aug. 4, 1 p.m., "Alzheimer's Disease," William Cutlip II, M.D.

Point Pleasant ☐ Pleasant Valley Hospital, Aug. 25, noon, "Cryosurgical Ablation of the Prostate," James P. Tierney, D.O.

Richwood ☐ Richwood Area Medical Center, Aug. 11, 5:15 p.m., "Management of Low Back Pain," Kenneth Wright, M.D.

Ripley ☐ Jackson General Hospital, Aug. 12, 12:15 p.m., "Chest Trauma," Frank C. Lucente, M.D.

White Sulphur Springs ★ The Greenbrier Clinic, Aug. 22, 4 p.m. "Prostate Cancer Prevention Trial," Unyime Nseyo, M.D.

★ The Greenbrier Clinic, Sept. 26, 4 p.m., "Breast Cancer," Edward Crowell, M.D.

** To be announced*

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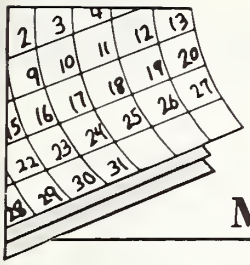


Medical Meetings

August

5-6–Quality Improvement in Healthcare: An Introduction (sponsored by the National Association for Healthcare Quality), Chicago

5-7–2nd Annual Conference of Civil War Medicine (sponsored by the National Museum of Civil War Medicine), Frederick, Md.

8-10–American Hospital Association, Dallas

14-17–Midwest Surgical Association, MacKinac Island, Mich.

17-20–WVSMA's 127th Annual Meeting, White Sulphur Springs

19-20–Healthcare Quality Management: Review and Study Session (sponsored by the National Association for Healthcare Quality), Boston

19-20–Communication Approaches for Tracheostomized and Ventilator Dependent Patients (sponsored by Voicing!, Inc.) Chapel Hill, N.C.

25-27–Southern Association for Oncology, Sea Island, Ga.

26-27–Case Management and Utilization Management in a Changing Healthcare Environment (sponsored by the National Association for Healthcare Quality), Pittsburgh

September

6-11–18th Annual Meeting of the American Academy of Neurological and Orthopaedic Surgeons, Las Vegas

8-10–American Gynecological and Obstetrical Society, Hot Springs, Va.

10-13–Seventh Annual Update in Internal Medicine (sponsored by Ohio State University), Columbus

11-14–American College of Emergency Physicians, Orlando, Fla.

16-17–Communication Approaches for Tracheostomized and Ventilator Dependent Patients (sponsored by Voicing!, Inc.), Louisville, Ky.

22-23–Tools and Techniques for Improving Clinical Outcomes: A Practical Seminar for Physicians and Clinical Leaders (sponsored by the Joint Commission on Accreditation of Healthcare Organizations), Atlanta

22-25–American Academy of Family Physicians, Boston

23-24–Prevention of Target Organ Damage in the Hypertensive (sponsored by Ohio State University), Columbus

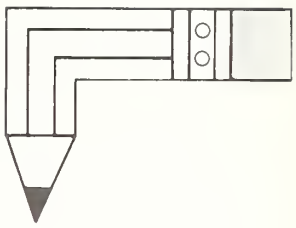
23-24–Transfusion Medicine of the Future (sponsored by the American Association of Blood Banks), Phoenix, Ariz.

24-30–XIV FIGO World Congress, Montréal

For More Information . . .

Contact the Journal at (304) 925-0342.

Poetry Corner



Seeking Knowledge

Seeking knowledge in a world
In which new knowledge spreads
In ever more expanding ways
Becomes a necessary fact of life.
To just stand still, ignoring growth,
Can leave one not just holding place,
But falling back and losing pace,
While getting out of step with those
Who see a need to move ahead, to grow;
To seek each moment opportune;
Take time to learn, to keep attune.

E. Leon Linger, M.D.

Please address your submissions for Poetry Corner to Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

"THAT'S NOT A HAIR ON TOP OF DR. CLAGHORN'S HEAD... IT'S A SHORT FUSE!"

Department of Health & Human Resources

Bureau of Public Health News

This page of material is submitted and paid for by the Bureau of Public Health.

Ten communities receive grants to create wellness programs

Ten community groups in the state have been awarded one-year grants from the Bureau of Public Health to conduct projects designed to improve the health of West Virginians.

The projects, funded through the Bureau's Community Health Promotion Program, total approximately $20,000 and include the following activities:

*The Brooke County Health Department, the Mercer County Board of Health, and Pleasants County Committee on Family Issues will assess community health needs and develop projects based on identified needs;

*Clay Organized for Wellness will sponsor various physical fitness activities for students and area residents;

*Doddridge County Planned Approach to Community Health (PATCH) will evaluate completed health promotion projects and reassess future health priorities;

*The Randolph-Elkins Health Department will develop worksite wellness programs for several area businesses;

*The E.A. Hawse Health Center in Baker will provide evening wellness programs at East Hardy High School;

*St. George Medical Clinic in Tucker County will provide exercise programs for children, ages five and under, and their parents;

*Ritchie County PATCH will coordinate nutrition education for middle school students;

*Monroe Health Center will work with county agencies and schools to provide driver's education and accident prevention programs.

The Community Health Promotion Program provides communities around the state with skills and resources to make informed decisions about allocating health resources. The program also helps to determine health problems and needs at the local level and to implement health programs and services. Currently, 30 of the state's 55 counties have created community health promotion sites, and efforts are underway to expand to every county by the year 2000.

For more details, call (304) 558-0644.

WVTCC outlines plans for decreasing tobacco usage in West Virginia

According to the recently released report by the West Virginia Tobacco Control Coalition, "*Five Years Toward a Tobacco-Free West Virginia,*" many measures will be taken during the next five years to dramatically curb the use of tobacco in the state. These actions, which will be taken by community leaders, health care providers and individual citizens, include passing clean indoor air regulations, increasing efforts to help patients stop smoking, and enforcing laws to prohibit the sale of tobacco products to minors.

Currently, nearly one-third of all West Virginians use some type of tobacco product, and the WVTCC's objective is to reduce this to 17% of the state population by 1998. To achieve their goals, the WVTCC's report emphasizes the need to target groups that have high tobacco-use rates or low quitting rates. Plans also call for raising the tax on cigarettes, restricting tobacco advertising and promotional events, increasing the number of worksites that prohibit tobacco use, and requiring a license to sell tobacco products.

Ten counties and five communities have passed clean indoor air laws or ordinances, and many others are trying to achieve these goals. A statewide clean indoor air bill passed the House of Delegates for the first time this year, but was not acted upon by the Senate. Legislation to control tobacco will again be introduced in January 1995.

For more information, contact the Joyce Holmes at (304) 558-0644.

New report details affects of violence during pregnancy

A study of pregnant, low-income women in the state shows that violence during pregnancy affects not only the abused women, but also their babies. According to the study, the unborn babies of women who are physically abused during pregnancy were almost four times more likely to suffer fetal distress or die before birth, and were three times more likely to remain in the hospital after the mother was discharged.

The study was conducted by interviewing participants in the West Virginia Bureau of Public Health's (WVBPH) Office of Maternal and Child Health Right From the Start Program (OMCH/RFTS) during 1991 and 1992. It was one of the first reports to show that violence against women during pregnancy can hurt the unborn child. Other studies have shown that violence against women escalates during pregnancy and may not even begin until a woman becomes pregnant. One of every six women taking part in the new study indicated she'd been abused during her current pregnancy, yet the authors believe the number of unreported acts of violence against pregnant women is higher. In nearly 80% of the cases in this latest study, the woman's prenatal doctor did not detect that the woman had been abused.

The findings were published in a paper entitled "*Violence, Pregnancy, and Birth Outcome in Appalachia,*" by Dr. Timothy Dye, former director of the WVBPH, Division of Research and Evaluation of the OMCH. The paper was co-authored by Nancy J. Tolliver, R.N., M.S.I.R., deputy director of the WVBPH; Dr. Richard Lee, head of the Division of Geographic Medicine at the State University of New York at Buffalo; and Catherine Taylor, M.S.W., former director of the OMCH/RFTS program of the WVBPH. Dr. Dye recently presented this paper at the American Psychological Association Conference on Women's Health.

For more information, call Nancy Tolliver at (304) 558-2971.

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ROBERT C. BYRD HEALTH SCIENCES CENTER
OF WEST VIRGINIA UNIVERSITY

Compiled from material furnished by the Robert C. Byrd Health Sciences Center of West Virginia University, Communications Division, Morgantown

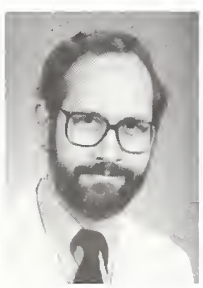
Jefferson Memorial, City Hospital become affiliated with WVU

Berkeley and Jefferson counties are now part of a "medical campus" for WVU students, thanks to an agreement signed June 17 at the VA Medical Center.

"Our students who train here will learn from physicians in these counties, and will contribute to medical care for everyone in the region," says Dr. Robert D'Alessandri, vice president for health sciences and dean of medicine. "We are proud to add City Hospital and Jefferson Memorial Hospital to our network of educational affiliates."

The VA Medical Center and the Shenandoah Community Health Center are already WVU affiliates, Dr. D'Alessandri said. The addition of the two community hospitals gives WVU students the opportunity to train in a full range of health care settings, and the educational agreement is a further development of the Eastern West Virginia Health Care Initiative.

Children's Hospital doctor receives award



Ritchie

Dr. A. Kim Ritchey, a cancer specialist at WVU Children's Hospital and WVU professor of pediatrics, received the Robitussin, Dimetapp and Wyeth Pediatrics Miracle Maker Award during a local segment of the Children's Miracle Network telethon.

This award recognizes outstanding pediatricians and physicians specializing in children's health care. The award's sponsors donated $3,000 to WVU Children's Hospital in Dr. Ritchey's name and presented him with a plaque.

Videoconferences on stress sponsored by Behavioral Medicine

The Department of Behavioral Medicine and Psychiatry is sponsoring a series of free videoconferences aimed at giving mental health professionals the opportunity to share work-related stress with colleagues throughout the state.

The videoconferences are being held the first Tuesday of the month through December. Topics being addressed include: the trauma model, re-enactment, dissociative regression, hearing voices, body memories and altered personalities. Each program airs from 11 a.m. until noon via Mountaineer Doctor Television (MDTV) at seven sites throughout the state: Grant Memorial Hospital, Petersburg; Davis Memorial Hospital, Elkins; Wetzel County Hospital, New Martinsville; St. Joseph's Hospital, Buchannon; Charleston Area Medical Center, Charleston; Boone Memorial Hospital, Madison; and the Robert C. Byrd HSC, Morgantown.

The videoconferences are being co-chaired by Dr. Louis W. Tinnin, professor, and Dr. Lyndra Bills, assistant professor of behavioral medicine and psychiatry.

For more information about the videoconferences, call Dr. Tinnin at 293-2411.

Charleston Division, CAMC host Visiting Clinician Program

CAMC is sponsoring a Visiting Clinician Program in conjunction with the Charleston Division of the Robert C. Byrd HSC, in order to expand the the Morgantown Visiting Clinician Program and to give participants the opportunity to work with physicians from both the Morgantown and Charleston areas.

Dr. Mitch Jacques, chair of the Department of Family Medicine, Charleston Division, is the program's medical director; and Melissa Long is the acting program coordinator.

Professor/chair of pathology chosen as leadership scholar

Sens

Mary Ann Sens, Ph.D., M.D., professor and chair of pathology, has been chosen as a leadership scholar in Academic Administration and Health Policy by the Association of Academic Health Centers (AHC).

This program recognizes senior level women and minority faculty members who have the potential to move into the top leadership ranks of academic health centers within the next few years. Scholars remain at the their home institutions while they participate for three years in the activities of the AHC that emphasize networking and mentoring.

Dr. Sens was nominated for this scholarship based on her efforts to minimize the use of animals in medical research, and for her work as a forensic pathologist in identifying acts of violence via pathology.

Beattie appointed to National Board of Medical Examiners

Beattie

Diane S. Beattie, Ph.D., professor and chair of biochemistry, has been appointed to the National Board of Medical Examiners as a test committee representative.

The National Board of Medical Examiners is a non-profit organization that prepares and administers qualifying exams for medical licensure. Dr. Beattie is involved in biochemistry test material development for the MLE.

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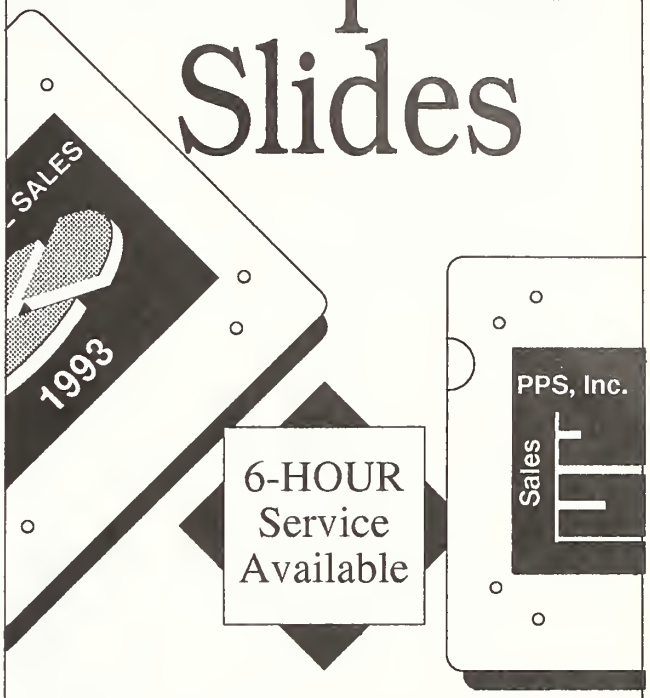

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Marshall University School of Medicine

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington

New research facility at VA Center to benefit medical education

In addition to enhancing medical care to veterans, a new research addition at the Huntington VA Medical Center will mean improved education for medical students, according to Dr. Charles H. McKown Jr., dean of the Marshall University School of Medicine.

Sen. Robert C. Byrd, Senate Appropriations Committee chairman, included the $9.9 million project in the 1995 VA/Housing and Urban Development Bill the committee approved July 14. The bill now goes for approval to the full Senate, the House of Representatives and the president.

Dr. McKown said veterans and students alike will benefit from the center's ability to attract an expanded range of physicians highly qualified to treat veterans and serve as medical school faculty.

"Typically, the very best physicians want to associate with a medical school, and usually they want to conduct laboratory research as well," Dr. McKown said. "The quality of our research has been absolutely outstanding, but lack of adequate lab space definitely has restricted the amount of research done and the scope of our research program."

The research building will be built adjacent to the Coon Medical Education Building, which houses classrooms, faculty offices and labs for the first two years of the medical school curriculum. The new building will have 28,660 gross square feet of space, enough for 10 to 12 modern research labs and support facilities.

Currently, Marshall/VA doctors are working on several VA research projects to prevent or better treat such widespread health problems as heart disease, diabetes, and infectious diseases. The labs for these projects are located in a old nurses' dormitory which is undersized and lacks the features necessary for conducting a more advanced medical research program, the dean said. Furthermore, the VA labs are at the opposite end of the medical center compound from the Medical Education Building.

"The new facility will allow our researchers to work more closely together and use resources most efficiently," Dr. McKown said.

The Huntington VA Medical Center had no research facilities when it became affiliated with the new Marshall University School of Medicine in 1977. By 1990, all space in the nurses' dorm was in use. Last year's opening of the Robert C. Byrd Clinical Addition underscored the need for improved lab facilities. The pressure for adequate lab facilities intensified with last year's opening of the Robert C. Byrd clinical addition. That addition, which doubled the center's patient care space, also increased the VA's need to recruit additional qualified physicians, including some in new specialty areas.

Several faculty receive tenure, promotions

Six Marshall University School of Medicine faculty received tenure effective July 1, and 11 received promotions.

The faculty members who received tenure and promotions were:

Anatomy, Cell and Neurobiology
Sasha N. Zill, Ph.D., promoted to professor;

Family and Community Health
Kathleen M. O'Hanlon, M.D., promoted to associate professor;

Medicine
W. Michael Skeens, M.D., promoted to associate professor;

Kevin W. Yingling, M.D., promoted to associate professor;

Microbiology, Immunology and Molecular Genetics
Donald A. Primerano, Ph.D., granted tenure and promoted to associate professor;

Obstetrics and Gynecology
Ted P. Haddox, M.D., promoted to associate professor;

Pathology
David C. Leppla, M.D., granted tenure;

Pharmacology
Monica A. Valentovic, Ph.D., promoted to professor;

Pediatrics
Yoram Elitsur, M.D., promoted to professor;

Joseph W. Werthammer, M.D., granted tenure and promoted to professor;

Social Work
Girmay Berhie, Ph.D., granted tenure and promoted to professor;

Jody Gottlieb, A.C.S.W., promoted to associate professor;

Surgery
James P. Carey, M.D., granted tenure; and

William M. Cocke, M.D., granted tenure.

Rhoten participates in seminar in Zimbabwe

Dr. William B. Rhoten, chair of the Department of Anatomy, Cell and Neurobiology, recently participated in a faculty development seminar hosted by the Council on International Educational Exchange in Harare, Zimbabwe.

The seminar emphasized issues relating to development in southern Africa, especially Zimbabwe. The topics discussed included the University of Zimbabwe Amendment Act and academic freedom, gender problems and AIDS-related diseases.

Alumni weekend set

Reservations are being accepted for this year's Alumni Homecoming Weekend, September 30 - October 1 at the Huntington Radisson.

Dr. Pat Brown's faculty/alumni mixer will be at 8 p.m. on September 30, and the CME meeting will begin the following morning at 8 a.m.

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Expanding our horizons

Dear Fellow Medical Students:

The WVSMA-MSS has been receiving a great deal of attention recently due to the Medical Student Survey that has been circulated to all medical students in the state. Two students from the Charleston chapter, Bonnie Bailey and Henry Higgins, have been compiling the results and they have reported that the surveys contain many valuable recommendations for improving our health care system. Once the information is tabulated, we plan to publish an article in the *Journal* and present the results to the members of the West Virginia Legislature.

Another recent highlight for the WVSMA-MSS was the Annual AMA Medical Student Meeting in Chicago, which seven of us from the three different campuses were able to attend. We had the pleasure of meeting medical students from all over America, and to observe how they came together on the assembly floor to accomplish a common stance on a variety of issues. Nick Cottrell, vice president of the WVSMA-MSS Executive Council, amended MSS Resolution 31 - First Aid Training For Child Daycare Workers, which was accepted. He also aided in the debate of the Physician Workforce Planning Strategies issue. In addition, as a result of A-94, we will be able to increase our contributions at next year's conference, as well as encourage more WVSMA-MSS members to participate.

In other news, the WVU Charleston Medical Student Society recently elected officers: Jeff Floyd-President, Christy Brodisch-Vice President, and Michael Cabral-Secretary/Treasurer. We are also in the process of creating a new component student chapter for students at the West Virginia School of Osteopathic Medicine in Lewisburg, and encouraging WVSOM students to become involved in the WVSMA-MSS.

The WVSMA-MSS Executive Council is currently writing amendments for our bylaws which would better define who will serve as delegates and alternate delegates to the national meetings. We also want to improve the election process for the Executive Council. Any amendment to our bylaws requires an affirmative vote by two-thirds of the active members in attendance at the Annual Business Meeting. If anyone has any suggestions for improving our constitution or the section in general, please contact your component society president. In addition, the WVSMA-MSS has submitted a resolution on graduate medical education to be presented at the WVSMA House of Delegates' meeting during the WVSMA Annual Meeting at The Greenbrier.

In conclusion, we are currently planning our Annual Business Meeting, which will be held next January in Huntington in conjunction with the WVSMA Mid-Winter Clinical Conference. The WVSMA-MSS continues to become a more active and influential organization and I am looking forward to a very productive fall.

David C. Faber, MS III
WVSMA-MSS President

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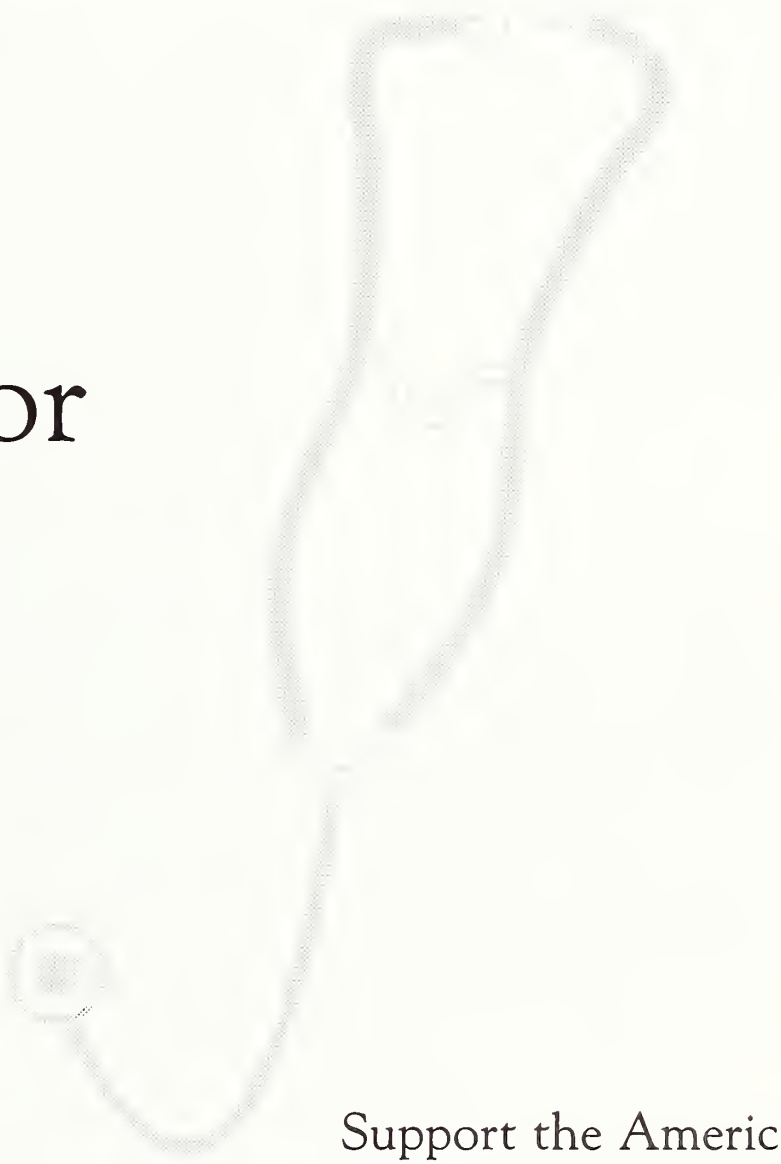

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West Virginia Medical JOURNAL

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Front Cover

A black bear enjoys his day at the West Virginia Wildlife Center in Upshur County. Photo by *Stephen Shaluta Jr.*, West Virginia Division of Tourism and Parks.

WVSMA staff members highlighted

George Rider

Executive Director

George functions as general manager of the WVSMA and oversees all staff functions; prepares and recommends the annual budget with the aid of the finance manager and oversees its implementation; recommends programs to the Executive Committee and Council; coordinates legislative activities; works with outside legal counsel; interacts with the Board of Medicine and the various publics; and supervises building maintenance and operations.

Nancie Divvens

Associate Executive Director

Nancie assumes the responsibilities of the executive director in his absence and serves as office manager; assists the Executive Committee and Council in carrying out the policies in the Constitution and Bylaws; coordinates the WVSMA Continuing Medical Education Accreditation Program, the Annual Meeting, the Mid-Winter Clinical Conference, and Speakers' Bureau; serves as the WVSMA liaison for Nationwide Insurance Company-Medicare Operations; develops non-dues revenue programs; administers travel policies for educational meetings; and directs two worldwide travel programs for members.

Michelle Ellison

Public Relations/ Advertising Manager

Michelle coordinates all public relations functions for the WVSMA; writes news releases; designs brochures and promotional materials; creates the monthly publication *Medical Newsline;* works with the finance manager to maintain all advertising accounts for the *West Virginia Medical Journal;* recruits new advertising for the *Journal;* interacts with the managing editor to determine advertisement placement; proofreads advertising copy; serves on the Publication Committee; updates the subscriber mailing list for the *Journal;* and acts as a liaison with county medical societies in developing mini-internship programs.

Nancy Hill

Managing Editor/ WV Medical Journal

Nancy writes news articles, edits and proofreads all copy, designs the layout of the pages, and takes photographs for the *West Virginia Medical Journal,* the WVSMA's monthly magazine; works with the editor, public relations/advertising manager and printer on various production aspects of the *Journal;* prepares financial statements regarding the *Journal* if needed; assists staff members with proofreading and creating news releases, correspondence, advertisements, brochures and other publications; and serves on the Publication Committee.

Shirleen Lipscomb

Executive Secretary

Shirleen functions as general assistant to the executive director, associate executive director, Executive Committee and Council; performs clerical duties, handles routine information and inquiries related to the daily operation of the WVSMA; coordinates the Physician Protection (Loss Control) Program and CME accreditation for hospitals and organizations throughout the state for Category I CME credit; coordinates visits of the WVSMA president and WVSMA staff members to the component societies; and assists in the planning and registration at the Annual Meeting, the Mid-Winter Clinical Conference and all other seminars and workshops sponsored by the WVSMA.

Misty Ramsey

Receptionist

Misty answers and directs incoming calls; coordinates registration for the Annual Meeting and the Mid-Winter Clinical Conference; orders and keeps inventory of office supplies; maintains office equipment and the WVSMA's computer system; types correspondence for the *West Virginia Medical Journal;* opens and distributes mail; assists with special projects; and compiles weekly computer backups of all office files.

Winnie Martin

Director of Government Relations

Winnie serves as executive secretary to the WVSMA Alliance and to WESPAC, the West Virginia Medical Political Action Committee; manages government relations by researching and analyzing legislative issues, lobbying the Legislature, monitoring interim committee meetings, and assisting with the WVSMA Legislative Committee; serves as liaison to the Council; writes and edits *WESGRAM,* WVSMA's bimonthly publication; *Legislative Update,* a weekly newsletter produced while the Legislature is in session, and *MedLink,* the WVSMA Alliance's newsletter.

Sue Shanklin

Finance Manager

Sue manages all WVSMA finances including the recording of all assets, liability, fund balance, accounts receivable, accounts payable, investments and employee benefits as needed; maintains biweekly payroll and employee leave records; prepares monthly general ledger and quarterly tax returns balance sheet, and profit and loss statement; assists and supplies financial data to the auditing firm for preparing annual audit and annual tax returns; prepares annual operating budget and financial statements for the treasurer, Executive Committee and Council; and serves on the Finance Committee.

Becky Peterson

Project Coordinator

Becky coordinates the program planning and development for the Annual Meeting and the Mid-Winter Clinical Conference; compiles appropriate data for applications and approval of continuing medical education hours; coordinates and assists support for the new programs and other projects for the membership; provides clerical support for the Annual Meeting Program and Mid-Winter Program committees and the Medical Education Committee; and assists the Executive Director, Associate Executive Director and the Executive Secretary as needed.

Donna Webb

Membership Coordinator

Donna keeps dues and informational records on all active, retired and student members; acts as WVSMA's liaison with AMA for membership activities; compiles and creates roster for members; recruits new members; interacts with county societies on membership matters; assists with special projects; serves as exhibit manager for the Annual Meeting and the Mid-Winter Clinical Conference; and updates mailing lists and prepares labels as requested by staff members and other organizations.

An overview of the AMA Annual Meeting

Members of the WVSMA's delegation at the AMA Annual Meeting included: (Front Row) Senior Councilor at Large Dr. Constantino Amores; Associate Executive Director Nancie Divvens; and President-Elect Dr. Denny Burton. (Second Row) Executive Director George Rider; Dr. Stephen Thilen; Dr. Robert Hess; Junior Councilor at Large Dr. James Bryant; and Council Chairman Dr. Robert Pulliam. (Back Row) Dr. David Avery; Vice President Dr. James Helsley; and President Dr. James Comerci. Not pictured is Dr. John Holloway.

The AMA's Annual Meeting took place in Chicago from June 12-16. Members of the WVSMA's delegation took an active roll with many of the reference committees, and I was fortunate to be able to serve on Committee H, which focused on health care data systems.

The House of Delegates debated 212 resolutions and 106 reports during the course of the meeting. A discussion on health care reform drew the largest attendance I have ever seen at an AMA Annual Meeting. As a result of this hearing, the AMA developed a policy to achieve universal access and coverage through an approach that would utilize employee and individual responsibilities. This new plan would maintain individuals' rights to chose their own their own physicians and insurance plans.

In other actions at the meeting, there was a strong effort to encourage the development of health savings accounts, and to support the health care reform plan that contains these interests. A reference committee also reaffirmed the policy AMA has for preserving and expanding physicians' rights to develop their own fee schedules and not have them restricted by outside forces.

The continuing problem of defining primary care was also debated at the meeting. As a result of these discussions, strategies were developed to help modify physician distribution by individual and local needs, not by arbitrary percent distribution. Plans were set into motion to create a National Health Work Force Advisory Council and Graduate Medical Education Commission.

The delegates focused much attention on the issue of childhood abuse and violence in America. Policy statements were established to recognize the fact that adult memories of childhood sexual abuse cannot always be proved, so this subject will be monitored by the AMA. In addition, the AMA continues to work with the AMA Alliance to prevent family violence and increase awareness of this problem.

Of all the subjects discussed at the meeting, though, the major topic was managed care. The House of Delegates developed policies to permit physicians to negotiate individually and collectively, and to provide formal input of physicians into the policies of the managed care organizations they are, or would be participating in.

A detailed summary of the actions taken by the AMA House of Delegates is available at the WVSMA office in Charleston. I hope that more WVSMA members will express their ideas and opinions to the members of our delegation so we can better represent you at future meetings.

David W. Avery, M.D.
AMA Delegate

An overview of the AMA-HMSS Annual Meeting

The Twenty-third Annual AMA Hospital Medical Staff Section (AMA-HMSS) Assembly was held June 9-13 in Chicago. The meeting was attended by 412 representatives, 23 alternate representatives, 81 observers, and 13 guests, whose contributions lead to a very productive, informative and educational session.

On the first night of the assembly, representatives had an opportunity to have a dialogue with three members of the AMA Board of Trustees. Board members fielded over 30 questions on topics that ranged from concerns about the Joint Commission's "Agenda for Change" to AMA's views on various aspects of health system reform. Through direct communication with AMA leadership, HMSS representatives were able to gain greater clarity on AMA policy and positions relative to medical practice issues.

In his opening address, AMA-HMSS Governing Council Chair Lee H. McCormick, M.D., spoke candidly about the evolution in health care and its implications for physicians, as well as the need for a restructuring of organized medicine to accommodate physicians now practicing in managed care networks. He also underscored the need for physician involvement to ensure positive health system reform changes.

In concert with Dr. McCormick's message, an educational program was conducted which focused on physician involvement in health system reform and offered strategies for dealing with change. The program was lead by Nellie O'Gara, a Chicago health care consultant, who warned physicians of the massive restructuring to form horizontally and vertically integrated systems, the rapid consolidation of managed care plans, and the imminent battle for control of premium dollars.

The next speaker, David Main, a health care lawyer from Washington, D.C., concurred with Ms. O'Gara and added that physicians are best positioned to take control because of their knowledge of managing care and costs. He also stated that physician-directed plans can provide patients with better value than other structures.

AMA's Associate General Counsel Edward Hirshfield then reviewed AMA's two legislative proposals: the Physician Health Plans and Networks Act of 1994, which would offer tax breaks and incentives for formation of physician-owned plans; and the Patient Protection Act, which would provide protection to physicians regardless of the plan's ownership and require plans to give patients and physicians information on coverage limits and contracting. In addition, he also announced AMA's Capital Pool Project, which seeks to bring physicians needing capital together with business planners, bankers, and other investors; and he explained AMA's push for antitrust relief to help facilitate physician networking.

Noah Rosenberg, a California-based health care lawyer, closed this session with a presentation on capturing the institutional revenue stream. He advised that a physician organization's assumption of institutional risk does not guarantee additional revenue to physicians, but requires them to work hard to manage medical care efficiently, while ensuring quality. He added that physician organizations must recognize the importance of the institutional dollar, and network together to retain the necessary medical management, as well as the financial and legal expertise for achieving success.

The AMA-HMSS Assembly adopted 18 Governing Council reports and 27 resolutions, nine of which were sent over to the AMA House of Delegates (HOD). Debate surfaced, both in the HMSS Assembly and HOD, over the Joint Commission's development of disclosure policies and hospital numerical report cards. The result was a new policy, which directs the AMA to ask the Joint Commission to oppose the release of Organization-Specific Compliance Information to the general public until the AMA-HOD has the opportunity to assess how the data are gathered, analyzed, validated and distributed. The policy also requests AMA representatives to the JCAHO Hospital Accreditation Program/Professional and Technical Advisory Committee (HAP/PTAC) to be appropriately involved in the development of disclosure policies and hospital numerical report cards. The Board of Trustees was charged with continuing its efforts to advocate AMA policy to the JCAHO with a plan for JCAHO accreditation of provider networks, public disclosure to standards compliance information, and the revision of the medical staff chapter.

Concerns also were raised about the use of proprietary practice parameters in utilization management. The AMA-HMSS alerted the HOD about the lack of involvement of national, state, and medical speciality societies in creating these guidelines and the possibility that such day-to-day protocols may become necessary constitute the practice of medicine. The HMSS was successful in obtaining support for AMA activities for ensuring that practice parameters are developed in compliance with AMA principles and the involvement of relevant physician organizations.

At this meeting, the AMA-HMSS also succeeded in gaining support for efforts to:

(1) Enhance fairness to patients and providers under managed care health benefit plans;

(2) Encourage those physicians who are entering into managed care organizations to do so by forming or participating in physician-owned or directed organizations;

(3) Implement the Capital Pool Project and include the AMA University Project, which provides training for physicians on the economics of managed care, marketing and position practice, administrative systems, and income prospects; and

(4) Sponsor the Physician Health Plans and Networks Act of 1994.

Norman W. Taylor, M.D.
Chairman of the WVSMA-HMSS

Hospital Medical Staff Section
24th Assembly Meeting
December 1-5, 1994
Sheraton Waikiki Hotel
Honolulu, Hawaii

Representation Education and Networking

Send a representative from your hospital medical staff and physician organization to the 1994 Interim American Medical Association Hospital Medical Staff (AMA-HMSS) Assembly Meeting held on December 1-5 in Honolulu. Aside from participating in the development of AMA policy, representatives will have an opportunity to network with colleagues, dialogue with the AMA Board of Trustees, and hear the latest news and information on health system reform.

With a changing health care environment, broader diversity within the physician population, limited resources, and an overriding need for unity of purpose and action by organized medicine, the AMA has undertaken a study of the Federation.

Federation Consortium Study

The study, involving county, state and specialty societies, the AMA, and other related organizations, intends to uncover useful information for developing ways to increase membership, member participation, and advocacy as well as improve communications, medical society performance, and resource utilization.

Project leaders have asked the AMA-HMSS to participate in the process because it effectively represents grassroot physician concerns. Input from each HMSS representative also will be extremely valuable in defining organized medicine in the future.

The 1994 Interim AMA-HMSS Assembly Meeting Education Program will host the Consortium study. Data collected and analyzed will facilitate the following objectives:

- Identify current and future needs, expectations, and preference of physicians and others for organized medicine;
- Explore membership ideas and options;
- Assess how medical societies relate to each other—including ways to be more supportive, avoid duplication of effort, leverage strengths, and better address weaknesses;
- Discover whether there are better tools/technologies that medical societies can use to communicate with one another and their members; and
- Enable medical societies to work smart in a more focused and purposeful way.

Plan to participate in the Federation Consortium on Friday, December 3 from 2:30 to 5:30 pm in Honolulu, Hawaii. Mahalo!

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A review of the treatment of intracranial metastases resulting from malignant melanoma

STEVEN J. JUBELIRER, M.D.
Director, Cancer Care Center of Southern West Virginia, Charleston Area Medical Center, and Clinical Professor of Medicine, West Virginia University, Charleston Division
MARK JONES, M.D.
Dermatology Resident, Medical College of Pennsylvania

Abstract

Malignant melanoma (MM) is often reported as the third most common cause of intracranial metastases after carcinoma of the breast and lung. A retrospective review of 49 patients with brain metastases from melanoma treated at CAMC between 1976 and 1991 was undertaken. Various factors (including age, sex, site and depth of primary lesion, sites of systemic disease, treatment modalities, and survival data) were analyzed. Of the 25 males and 24 females in our study, all but three patients had primary lesions greater than 1.5 mm. in depth. At least 80% of these patients had primary lesions of the trunk, head/neck, or upper extremity. The median interval between the initial diagnosis and development of brain metastases was 19 months. Complete surgical resection followed by radiotherapy resulted in the longest median survival of 8.3 months; and median survival for the entire group was 3.2 months. The outcomes of this study show that complete surgical resection with adjunctive use of whole brain radiation, should be attempted whenever possible, especially in patients with solitary lesions.

Introduction

Malignant melanoma is the third most common cause of central nervous system (CNS) metastases, preceded in incidence only by carcinoma of the breast and lung (1). Between 6% and 46% of patients with melanoma develop CNS metastases, often the precipitating terminal event (1). In addition, approximately one-third of all patients with melanoma die because of CNS involvement, regardless of the treatment strategies employed (2).

In order to define the clinical picture and efficacy of therapy for these patients, we studied the cases of all the individuals with this diagnosis who were treated at CAMC from 1976-91.

Methods

We reviewed the tumor registry and hospital records of all patients treated at CAMC from 1976-91 who had both a histological diagnosis of melanoma and a metastatic brain tumor, which was confirmed by CT scan, MRI, or radionuclide brain scan. Patients with meningeal seeding of tumor but who did not have intraparenchymal brain metastases were excluded.

We sought information regarding age, sex, site and depth of the primary lesion, extent and sites of systemic disease, number of brain metastases, interval from initial diagnosis to brain metastasis, modalities of treatment, and survival. Survival was measured from the time of diagnosis of the brain metastases.

Patient characteristics

Of the 320 patients with malignant melanoma seen at CAMC during this time period, 49 were found to have brain metastases. There were 25 males and 24 females, ranging in age from 21 to 85 years, with a median age of 56 years (Table 1). All patients were Caucasian.

The initial primary lesion was located on the thorax or abdomen in 19 patients, on the head or neck in 10, on the upper extremity in 10, in the viscera in three, on the lower extremity in one, and was unknown in six of the patients (Table 2). For some of the patients, the depth of the primary lesion was noted (Breslow's classification ranged from 0.6 mm. to 7.6 mm. with a median of 2.8 mm.). The interval between the diagnosis of the primary lesion and subsequent intracranial metastases ranged from one to 122 months, with a median of 19 months (11 months for males; 23 months for females).

Symptoms and signs of cerebral metastases varied depending on the location and the extent of the metastases. Confusion or disorientation, headaches, focal deficits, and seizures were the most common clinical manifestations encountered in these patients (Table 3).

At the time of diagnosis of brain metastases, 78% of these patients had recurrent or metastatic melanoma elsewhere (Table 4). Lung metastases were found in 16 patients, subcutaneous metastases in 16, liver metastases in six, bone metastases in five, breast lesions in one, and adrenal metastases in one.

Methods of diagnosis

Brain metastases were diagnosed by CT scan in 36 patients (73%), by MRI in three (6%), by radionuclide brain scan in two (4%)), by biopsy in four (8%), by angiography in one (2%), and by autopsy in one (Table 5). Thirty-five patients (71%) had multiple brain metastases and 14 had a solitary metastatic lesion.

Table 1. Age Distribution at Primary Diagnosis

Age (Years)	Number of Patients
21 - 30	4
31 - 39	10
40 - 49	8
50 - 59	8
60 - 69	14
70 - 79	4
> 80	1

Table 2. Site of Primary Lesion

Site	Number of Patients
Thorax/abdomen	19
Head and neck	10
Upper extremity	10
Visceral	3
Lower extremity	1
Unknown	6

Therapy

Forty-eight patients received whole brain radiotherapy, 38 of whom received concomitant corticosteroids. Twenty-seven patients were treated with chemotherapy and six received immunotherapy (interferon-alpha in five and BCG in one).

Six (42%) of the 14 patients with a solitary metastasis underwent craniotomy prior to radiation. All 14 patients received a mean total dose of 3,980 cGy of whole brain radiation (WBRT) in 10 fractions, 440 of which were coned down to the primary lesion. Of the three patients who had follow-up CT scans, two showed improvement.

The 35 patients who had multiple metastatic lesions received a mean of 3,509 cGy in 10 fractions. One of these patients underwent a craniotomy prior to WBRT. Of the five patients in this group who had follow-up CT scans, only one showed improvement.

Twenty-two patients (45%) reported subjective improvement after treatment was completed (eight with a solitary lesion) (57%), and 14 (40%) with multiple lesions). Ten patients reported no change in neurologic function, four reported worsening function, and no information was available concerning 13 of the patients.

Survival rates

The median survival of the patients with a solitary metastatic lesion was 8.3 months (range 24 days - 12.5 years), compared to 3.2 months (range 0 - 2.2 years) in those with multiple metastatic lesions (Table 6).

In the group with a solitary metastatic lesion, the median survival of those undergoing craniotomy followed by radiotherapy was 8.3 months, while the survival rate for those receiving radiotherapy alone was 5.8 months. The overall one-year survival rate was 14.2%; and the one-year survival rate of those with a solitary lesion and those with multiple lesions was 35% and 7.6% respectively.

The cause of death was determined in 33 patients. Eighteen patients (54%) died of recurrent intracranial metastases, 11 patients (33%) of cardiopulmonary arrest, one patient of hypovolemic shock, and one patient of septicemia. Only two patients are alive; one 14 months and one 36 months after the diagnosis of brain metastases. No correlation could be found between the time interval from initial diagnosis to brain metastasis, and from brain metastasis to death (linear correlation co-efficient = 0.04). The one patient who is alive and well more than 36 months after brain metastasis had an 18-month interval between initial diagnosis and brain metastasis.

Table 3. Clinical Manifestations of Brain Metastases in Patients with Melanoma at Initial Presentation

Signs/Symptoms*	Number	%
Confusion, Disorientation and Mental Deficit	22	45
Headache	21	43
Focal Deficit	26	47
Motor Deficit	19	
Cranial Nerve Paralysis	3	
Sensory Deficit	3	
Ataxia/Gait Disturbance	1	
Seizure	6	12

* Many patients presented with more than one manifestation

Table 4. Sites of Extracranial Metastases*

Site	Number
Lung	16
Subcutaneous	16
Liver	6
Bone	5
Adrenal	1
Breast	1

* Patients with multiple metastases were noted in each category where lesions occurred.

Table 5. Method of Diagnosis

Method	Number
CT-Scan	38
Biopsy	4
MRI	3
Brain Scan	2
Angiography	1
Autopsy	1

Table 6. Clinical Courses of Patients with Solitary vs. Multiple Metastatic Lesions

	Solitary Lesion	Multiple Lesions
Number of Patients	14	35
Median Survival (months)	8.3	3.2
% with Liver or Lung Metastasis	21	46
Symptomatic Improvement after Treatment	57	40

Discussion

Several diagnostic features were noted to be associated with a much higher evidence of brain metastases.

Patients with more invasive primary lesions as reflected by deeper Breslow's levels, and patients with primary lesions of the head and neck, trunk, or upper extremity, all had a greater risk of developing CNS metastases. All but three patients in our series had primary lesions greater than 1.5 mm. in depth, and in at least 80% of the histories we studied, patients had primary lesions of the trunk, head and neck, or upper extremity. Each of these features has been reported previously to be associated with a poor general prognosis, which may well be due to this increased incidence of CNS metastases (3,4,5,6,7,8,9). In the case of the deeper Breslow's (or Clark's) level, the incidence of metastases seems to be related to the greater likelihood of a general dissemination of the disease, a conclusion supported by the higher frequency of positive regional lymph nodes with deeper lesions (8).

Survival of patients with brain metastases from melanoma has been uniformly poor. The median overall survival rate of 3.2 months in our series is similar to that found by Allan and colleagues (10) in their review of greater than 750 patients with brain metastases. Sampson et al (11) reviewed 6,953 melanoma patients, and for the 702 who had CNS disease - the median survival time was three months. As noted in Table 7, there are very few long-term survivors despite the multiple modalities of treatment used.

Surgical resection offers patients the greatest chance for survival and clinical improvement, particularly in patients with solitary lesions. The median survival of our patients with

single lesions treated with surgery and radiotherapy was 8.3 months, compared to 5.6 months in those treated with radiotherapy alone.

Numerous retrospective studies have indicated a greater median survival in those individuals with surgery ± whole brain radiotherapy (WBRT) compared to radiation alone (26). A recent prospective randomized trial was performed in which 48 patients with known systemic cancer (some of whom had melanoma) were treated with either biopsy of the suspected brain metastasis plus WBRT or complete surgical resection of the metastasis plus WBRT. The radiation doses were the same in both groups and consisted of a total dose of 3,600 cGy given as 12 daily fractions of 300 cGy each. There was a statistically significant increase in survival in the surgical group (40 weeks vs. 15 weeks). In addition, the length of time until the brain metastases reoccurred and the duration of functional independence were significantly longer in the resection group.

Evaluating the clinical response of metastatic brain tumors to radiation surgery or chemotherapy is difficult. The failure of other organ systems may mimic progressive neurologic disease even when treatment has been effective. Furthermore, the marked salutary effect of corticosteroids on brain tumors makes it difficult to measure the clinical response to other modalities of therapy while steroids are being administered. Thus, the change in CT or MRI scan after therapy is an important indication of response. However, few patients in other studies (14,17,19,25) or in our own series had follow-up CT scans.

Stereotactic radiosurgery is an attractive therapeutic strategy less invasive than other modalities that provides high-dose, single-session irradiation to a localized tumor volume. Recent reports indicate that radiosurgery is being used in an increasing number of patients with metastatic cancer, particularly in those with tumors less than 3 cm. in diameter (28,29,30). A randomized prospective trial is underway in several institutions that are evaluating the use of radiosurgery for multiple metastases (two to four tumors) including melanoma. Patients are randomized to receive either fractionated WBRT (30 Gy) plus radiosurgery or WBRT alone. A separate randomized trial comparing WBRT (30 Gy) plus radiosurgery to radiosurgery alone in patients with newly-diagnosed solitary CNS lesions is also ongoing (30).

Table 7. Survival Data of Patients with Brain Metastases from Malignant Melanoma: Comparison of CAMC and Published Series

Investigator	# of Pts.	Primary to CNS Metastasis (yr.)	Median Survival (Months)	> 1 yr. Survival (%)	> 2 yr. Survival (%)
Saha et al 9	117	3.5	4.7	9	3
Amer et al 12	56	3.9	4	10.7	< 3
Choi et al 13	194	2.5	3	12.4	2.5
Retsas et al 14	100	2.5	2.5	8	4
Madajewicz et al 15	125	-	2.25	< 5	< 2
Stevens et al 16	129	3.5	5	-	7.7
Byrne et al 17	81	2.5	-	2	1.2
Beresford et al 18	37		2.6	2.7	0
Gottleib et al 19	41		2.9	2.4	0
Hilaris et al 20	27		1	3.7	0
Carella et al 21	60		3	3.3	< 1
Straus et al 22	20		-	-	-
Atkinson et al 23	113		4	1	0.9
Vlock et al 24	46		3	4.3	1
Stewart et al 25	18		2.5	5.5	0
Present Study	49	1.6	3.2	14.2	2

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Noise and hearing

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Abstract

This article addresses the various types of hazardous noise, their effects on hearing, and the factors which contribute to noise-induced hearing loss. The means of protecting hearing, both by reducing the emission of noise and the use of personal protection, are also discussed in detail.

Introduction

Noise pollution is a widespread phenomenon. Except in some remote rural areas and in primitive, underdeveloped countries, exposure to sometimes hazardous noise cannot be avoided, especially in industrialized countries.

Retrospective and prospective studies have concluded that noise up to the level of 85 decibels is not hazardous and will not affect the hearing. Noise above this level, though, will cause damage to hearing; and the louder the noise and the longer the exposure, the more damage that will occur to the hair cells (1,2,3). OSHA published guidelines of the permissible length of noise exposure to various levels of noise using the TWA (4) (time-weighted average) (Table 1). Hearing conservation measures are required anytime the intensity and duration of noise exceeds the safe level or when workers exhibit permanent threshold shift.

Effects on the cochlea

Hazardous noise can cause vascular changes of the cochlea, causing metabolic and electrolyte disturbances which lead to progressive deterioration of the outer hair cells first and then the inner hair cells. Gunfire and other explosive noises will cause direct mechanical damage to the hair cells (5,6,7,8).

After initial exposure to a hazardous noise, the individual will experience a temporary threshold shift followed by some recovery, but in most instances, the recovery is not complete. Permanent threshold shift is the result of exposure to damaging levels of noise.

Hearing loss results from long-term exposure to hazardous noise and the cumulative effect of noise on the hair cells. The first frequency to be affected is the 4,000-hertz frequency with its typical notch (9,10) (Figure 1). However, after continuous exposure, the higher frequencies will follow suit, and then the mid-frequencies. The last, and the least, to be affected are the low frequencies. After years of noise exposure, an audiogram will have the "ski slope" pattern (Figure 2).

Non-industrial exposure

Noise exposure can be divided into two categories: non-industrial and industrial.

This first type includes some common environmental noises (Table 2) and the following sources can generate hazardous levels:

1. **Shooting** that results from hunting, target shooting, basic military training, and home defense can generate sound that can reach 140-150 dBA SPL level which can directly destroy the hair cells. The effects of explosive sounds vary, depending on whether the blast occurs in a closed or open area, the distance of the firearm from the ear, whether the person is wearing ear protection or not, the number of rounds, and the length of exposure. Hearing loss is generally asymmetrical and is worse in the ear opposite to the predominant side due to the way the weapon is held and the position of the head.
2. **Motor sport vehicles** such as speed boats, racing cars, motorcycles, snowmobiles, water scooters, model cars and airplanes.
3. **Hobbies and daily practices** that involve carpentry and craft tools, lawn mowers, leaf blowers, blenders, and vacuum cleaners.
4. **Music** at some rock concerts can generate noise levels up to 130-140 dBA at 20-40 feet away from the stage. Exposure to these levels of noise for two hours to three hours will cause hearing damage. In addition, other types of concerts and loud car stereos inside closed windows, radio headsets blasting directly into the ears, tape recorders, big bands, discotheques, and concerts can also be damaging to the hearing.
5. **Miscellaneous sources** such as games and events in sports arenas, toy guns, arcade video games, whistles and fireworks.

Industrial noise exposure

There are two kinds of hazardous industrial noises: continuous noise, such as noise emitted from turbines; and impact noise, such as banging metal on metal, which can directly damage the hair cells. Hazardous industrial noises predominantly affect the high frequencies and generally save the low frequencies.

Noise is the most hazardous when it occurs in closed spaces with reverberation, and the industries that are the most dangerous are the following:

TABLE 1. Time Weighted Average (TWA) Developed by OSHA

Hours Per Day	Safe Sound Level (DBA)
8 hours	90
6 hours	92
4 hours	95
3 hours	97
2 hours	100
90 minutes	102
1 hour	105
30 minutes	110
15 minutes or less	115

TABLE 2. Sound Levels of Common Environmental Noises

Type of Sound	Loudness (DBA)
Whisper	20
Low Street Noise	40
Normal Conversation	60
Heavy Traffic	80
Truck, Lawn Mower, Subway	90-100
Airplane	120
Jet Engine	130-135
Gunshot Blast	140-150

1. **Underground mining.**
2. **Oil-drilling.**
3. **Lumber and wood.**
4. **Paper.**
5. **Primary and fabricated metals.**
6. **Food.**
7. **Textile.**
8. **Rubber.**
9. **Plastic.**
10. **Utilities.**

Hearing loss from industrial noise exposure is usually progressive and symmetrical. However, it can be asymmetrical in truck drivers (11,12), shingle sawyers (13), and some miners.

Contributing factors

Animal studies and human retrospective studies suggest that there are some contributing factors to noise-induced hearing loss. Circulatory diseases such as arteriosclerotic changes (14,15,16,17), hypertension (18,19,20,21,22), vascular changes, smoking (22,23), and diabetes (25,26,27,28), will increase the susceptibility of the cochlea to noise, leading to more severe hearing loss. Metabolic diseases such as hypolipoproteinemia, hypercholesterolemia, and high serum lipids (29,30,31,32,33,34,35) will increase the vulnerability of the cochlea to noise due to vascular changes caused by these diseases.

Age is another factor known to effect hearing loss since older ears are more susceptible to noise than younger ones, even though the majority of noise-induced hearing loss occurs in the first 10 years of noise exposure. Age also causes presbycusis (4). NIOSH, OSHA and ISO 1999 have published charts of the expected hearing level at each age in males and females.

Other factors which can aggrevate noise-induced hearing loss include some ototoxic and industrial chemicals (36,37,38).

Hearing conservation

The level of noise emitted from any source can be controlled by either reducing the loudness or by using newer technology and different manufacturing techniques such as insulating panels. Newer and quieter equipment will become more widespread in the future when factories upgrade their equipment and machinery; however, this is a very expensive process.

Personal protection (44,45,46,47,48), such as the use of ear muffs and ear plugs, is more economical and offers the best hope of preserving hearing. Several kinds of ear muffs are available and some can be worn alone or with hardhats, and some have a microphone for communication. The protection given by ear plugs varies, depending on the type of plug. The best results can be achieved from the foam-rubber ear plugs which will achieve Noise Reduction Rates (NRR) of up to 40 decibels.

The important factor is whether or not these protective devices are used properly, and not just set aside and worn only when the supervisor or the health/safety inspector appears. This is apparent in the discrepancy in the NRR measurements in the laboratory versus measurements in the workplace. Many workers resist wearing the hearing protection devices since they need hearing acuity

Figure 1. 4000 Hz. Notch

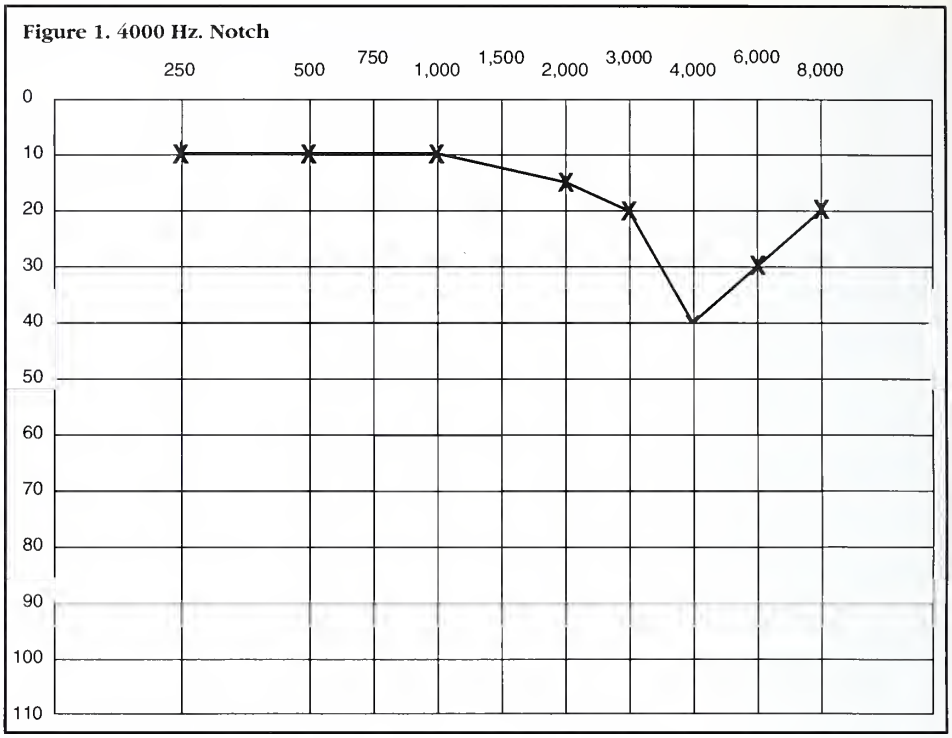
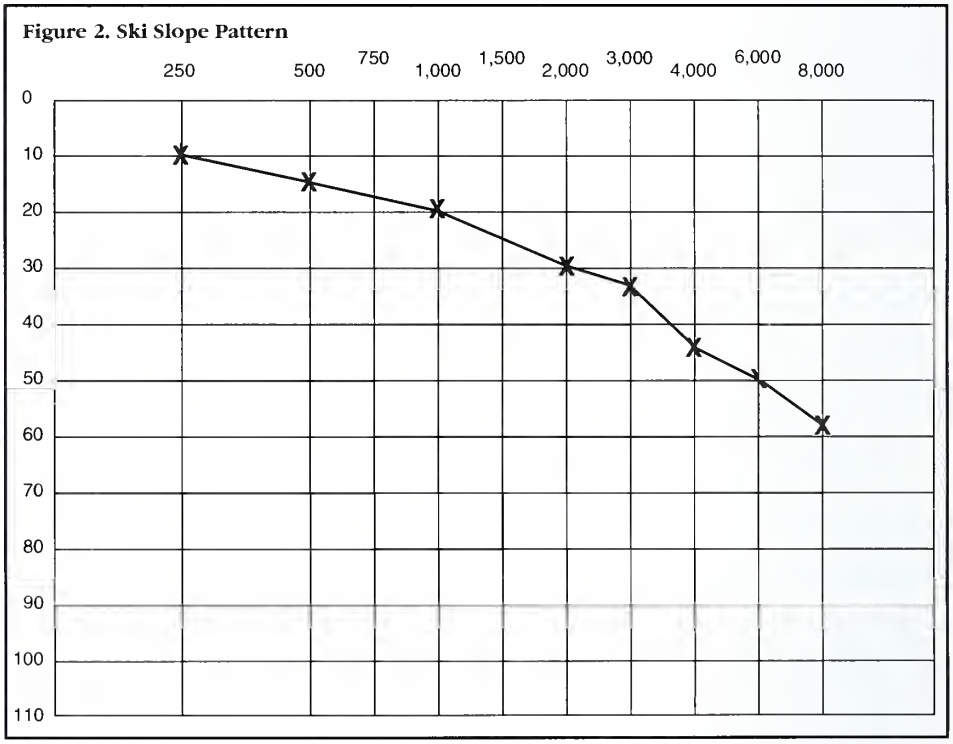


Figure 2. Ski Slope Pattern



to detect any immediate danger, i.e., crackling sounds from an imminent collapse in a mining shaft.

Newer kinds of electronic ear plugs are now being developed. They generate sounds which neutralize and cancel the incoming waves, allowing only the safe sound to penetrate the plugs. In another new type of protection, hazardous noise activates a valve eliminating the damaging noise. More research is underway and is needed to perfect these various hearing devices.

Other means of controlling noise include having baffles in public places such as gyms, civic centers, etc., to absorb noise and bring it closer to safe levels. Behavioral measures can also protect the hearing, i.e., control of hypertension, a low-fat diet, prevention of cardiovascular arteriosclerotic disease, control of diabetes, and cessation of smoking will reduce the susceptibility of the cochlea to noise.

Summary

Noise-induced hearing loss is insidious and slowly progressive. Intensive public education is needed to inform the public of the danger of exposure to noise, both industrial and non-industrial.

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How healthy are teens in Russia and Estonia?

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Abstract

This article is a commentary on the health of adolescents in St. Petersburg, Russia, and Tallinn, Estonia. It includes observations on general conditions in these two cities, which were made during a brief visit in October 1993 with a group of specialists in adolescent medicine.

Introduction

I had the opportunity to visit St. Petersburg, Russia, and Tallinn, Estonia, in October 1993 with seven other members of the Society of Adolescent Medicine. Originally, we had been invited to start our tour in Moscow, but because of the disturbance in early October at what is now called "The Black and White House," our travels had been shortened to just these two cities.

Flying into Russia, we saw firsthand that Russian communities are very willing to replace all remnants of Leninism. The old sign "Leningrad" in the airport terminal has been replaced by "St. Petersburg." The change of names nevertheless is minor compared to the multiple drastic changes going on across the country.

Since Perestroika, there is no denying problems and no attempt to cover the financial and political chaos. The Russians, though, accept their situation with equanimity and good humor. Our guide laughingly told us, "It costs as much for a box of spaghetti as I pay for one month's utilities in my apartment. Isn't that funny? We have troubles, oh yes, we have troubles but things are going to get better."

Even though our visit was to be a brief one, we hoped to gain insight into the country's health care system and the welfare of its youth.

Tourism

Tourism is a very important business for the Russians because so many people depend on it for a living.

Pushkin, an enormous palace just outside of St. Petersburg which was completely devastated during World War II, has been proudly rebuilt and is now opened for display. This ornate structure is filled with multiple kinds of precious stones, mosaic wood, masterpieces of art, tables with gold, fancy china place settings and all the trappings of affluence. Along the approach to this impressive building, hundreds of people who are unprotected from the snow and cold try desperately to sell trinkets to the visitors. When I mistakenly took out a ten instead of a one dollar bill, a dozen young people hustled around shouting and urging me to buy something.

The hotel we stayed in was very modern. Across from it was a monument which the Russians erected in honor of their soldiers and citizens who so courageously defended Leningrad against the full weight of fascism in the World War II. It is an impressive tower of precious stone flanked by two rows of heroic statues representing the people who were sacrificed. Adjacent to it is an underground sanctuary and an eternal flame. In sharp contrast to this lavish glorification of the past, this area is now where children beg for coins, young men aggressively sell trinkets and adult women make a living by pick-pocketing.

The city, itself, seems flat and drab. Newer streets are wide, but many of the downtown streets are very narrow which creates a very difficult situation for two-way traffic. The buildings are shabby with paint crumbling.

In the summer, tourists are taken to summer home of Peter the Great. The extensive grounds at this palace are landscaped with shrubbery, fountains and multiple water displays, but there are no lavoratory facilities available.

Adolescents

In the several hospitals we visited, some of the young people who required acute care were in bed, a few were in traction, but many of them were dressed in street clothes and walking around. They appeared clean but not well off.

Pasty complexions were consistent with the diet described by our guide. When asked if children went hungry, she said, "Oh no! They can always get bread and usually potatoes and cabbage." All patients were thin; very few Russians appear obese.

For the most part, the young people appear placid, but we were taken to some mental hospitals where we found many patients extremely depressed. Teenagers may be admitted voluntarily to psychiatric hospitals where the care is free of charge. The average stay for substance abuse is 30 days - 40 days. Follow-up care is fragmented.

Children in the orphanage we visited seemed especially well off. The director expressed concern about the children's health and lives in general. She seem starved for reading material and information and stated that professional people had been denied access to literature for 40 years.

Adolescents have always had their lives regulated for them. Before they are 17 years of age, both boys and girls receive a judicial document indicating their career evaluation. (There are nine volumes of guidelines detailing 400 professions.)

At age 17 and again at 18 years of age, all males have mandatory military exams. Only 0.6% are refused the military service, although exams revealed that 30% of the youths were disabled and 50% had limiting physical conditions. After one and one-half years of this mandatory service, males return to the occupation previously decided for them.

Statistics revealed that 90% of the teenagers in the country smoke, and that smoking among females had increased dramatically during recent years. The Russians are anxious to pass a law prohibiting tobacco advertising. Marijuana is home grown, chemically hazardous and expensive. Teenagers are also using tranquilizers. In general, the drug problem is limited due to the economic conditions of the people. Just as Americans do in our own country, the Russians blame the drug problem on importation from other countries.

Teenage pregnancy is seen as a problem and there is little discussion of promoting abstinence as a solution. Oral contraception has limited availability, and the people do not have Norplant, Depo-provera or any of the newer contraceptive agents. Suggested contraception methods we read about in their literature included using the rhythm method, coitus interruptus, lactation, masturbation, sterilization and abortion. The average Russian woman will have four or five abortions in her lifetime; some many more.

The government, of course, pays for the abortion. An adolescent with a

positive pregnancy test is sent to a women's hospital where she receives free care. This system provides no incentive to educate young people for responsible sexual activity. Until the last five years, statistics were not publicized or even gathered. At this time, gonorrhea and syphilis are diagnosed and treated, but human papilloma virus and herpes are overlooked because treatment is not really available.

HIV is not yet a major problem. All young men are checked as they enter the military service. Since 1987, of the 5 million people examined for HIV, only 65 were found positive -- a rate of .13/1,000. In 1992, statistics were given on another half million people and reports then showed a positivity rate of .08/1,000. In Russia, restriction of travel and immigration may indeed have been helpful in preventing HIV and AIDS. Nevertheless, the young people are sexually active with no effort to use condoms which are limited in supply.

Government health care

The entrance to the St. Petersburg health department was through a courtyard behind the building with trash piles, rubbish and an old ambulance with a cat lying in front of it. After walking through several hallways, up many flights of stairs and through a series of rooms, we ended up in a neat orderly conference room.

The professional discussion, in sharp contract to the surrounding ghetto, sparked deep admiration for the staff and their hard work. The doctor in charge of teenagers spoke openly of the mistakes that they had made and spent a long time with the group discussing their program and how they wanted to improve it.

The city of St. Petersburg has a population of 5 million and it is divided into six regions, 25 districts, and six suburbs. The city has 95 hospitals, 37,000 beds and 300 polyclinics. Twenty-six of the 95 hospitals have wards for teenagers.

Everyone must register in a polyclinic, and these facilities are usually three stories high with three departments: inpatient, outpatient and pediatric. Clinic doctors make house calls if needed, and all people have access to the same basic care. This basic care is limited not by the number of staff, but by funds for drugs, small equipment and supplies such as gloves. Since there is little mobility, there is no expectation or demand for choice.

The shortage of paper, which results in a lack of professional cards, table paper, napkins, and toilet tissue, did not seem to limit the papers required to place an order for medical supplies. At our meals, we were fortunate to have tiny triangular napkins. A total of eight napkins were made from a 10-inch paper square. Tourists are encouraged to bring their own toilet tissue.

Access to medical care is no problem. In January 1993, the free health care system was replaced by a mandatory medical insurance program. Nevertheless, local governments pay the premiums for children, students, disabled individuals living on pensions, and people who are unemployed. Many organizations are still financed on the government budget, and, if a private enterprise is losing money, the government is forced to pay the premium.

Access to care, however, does not assure healthy people, and Russia has major health problems. For example, even though immunizations are reportedly required, whooping cough was often discussed by physicians and we saw a patient with tetanus, which the staff said occurred about twice a year. One physician stated that 70% of the babies born in the country were abnormal because they were born with conditions such as congenital anomalies, fetal alcohol syndrome and encephalopathy. In addition, statistics on 1,000 teenagers indicated that only 2% were fully healthy; 35% had chronic disease; 65% were considered at risk for serious diseases; and 80% required further medical consultation.

Finance, food and sanitation

What good is access to health care without the financial and social structures to provide nutrition, sanitation and productive lifestyles?

In Russia, the collapsed financial structure leaves the ruble worthless in the world market. Since the exchange rate was 13 rubles to $1 in October when we visited, private traders preferred to be paid in U.S. dollars.

The Communist regime ignored villagers pleas and denied individual families the right to grow some of their own food and providing their own shelter. There apparently are a few private dachas for the wealthy, but single family homes are strikingly absent.

The Russian citizens we talked to told us that the problem was conflict between the reformist government and the conservative (Communist) parliament which Yeltsin dissolved in October. The Russian Central Bank has pursued "loose" monetary policies. Most powerful companies have borrowed at negative real interest and have stockpiled output in anticipation of higher prices. Prices escalated monthly as evidenced by the following rates in August and October 1993:

1. A ride on the metro increased from 36 kopek to 25 rubles;
2. The average monthly phone bill rose 2 1/2 rubles to 600 rubles;
3. The cost for a breakfast went from 13-15 kopeks to 120 rubles.

Milk is imported. Long lines of people can be seen holding half gallon containers awaiting a small truck with a 50-gallon tank which pulls up each day. A container of milk with fruit (yogurt) can be purchased for 100 rubles.

Sixty percent of the profits manufacturers earn is paid out for the salaries of the workforce. In regards to bread, the peasants obtain 28% of the price for wheat; the breadmaker receives 28%; and the store that sells the bread gets 28%. Presumably the government, which still runs the food supply, takes in the balance.

Grocery stores are poorly stocked. For less than $1, a person could buy three tiny oranges or a cabbage, and canned tomatoes with faded labels. The meat counter we observed contained a few small, dark, bony cuts and a few small, scrawny chickens. Cigarettes cost 30 rubles/pack.

In the Communist era, everyone had a job. Since Perestroika, a person works at as many jobs as he/she can. A good salary of 60,000 rubles/year converts to perhaps $6,000/year. Physicians make much less, about $60-$100 a month. Some of the prices, when converted to U.S. dollars seemed reasonable, but based on the average Russian salary were totally unreasonable.

Another problem we discovered in St. Petersburg was filthy lavatories, even in the medical facilities. At the same time, newspapers tell of the difficulty of avoiding hepatitis among hospitalized patients. Reportedly 42% of the hospitals have no hot water, 18% have no sewage systems, and 12% have no running water (1).

The crumbling financial and legal structure opens the doorway to crime. Several times our group noted the warning to watch our pocketbooks.

Tallinn, Estonia

Estonia, a Baltic country occupied by the Soviets from 1949 to 1989,

regained its independence and is very different from Russia. Anyone unaware of this, should ride the sleeper from St. Petersburg to Tallinn.

Travelers, warned that guards on the job at 3 a.m. might not be happy, were advised to be quiet and cooperative. First, the train stopped and the heavy-booted Russian guards marched down the aisle. Then, after a period of time just long enough for one to fall back to sleep, the Estonian guards clambered noisily in, banged open the compartment door, flipped on the overhead lights and stomped into the compartment room. Three different times they were in and out and I began to wonder what they were looking for or at -- especially since my roommate in the upper bunk just happened to be an attractive female.

Tallinn, Estonia, compared with St. Petersburg, was neat and clean. Repaired sidewalks and roadways, tidy and freshly painted buildings gave the city an aura of progress. We were surprised to see someone sweeping the gutter -- a practice seen in Russia a decade ago, but not recently. The stores seemed stocked and prosperous. There were fresh fruits and vegetables available in Estonia that were not offered in Russia, but they were priced very high according to our guide.

The hospitals in Estonia were more modern, and they were doing cardiac bypass and other high-tech procedures. Estonians have just legislated a 13% tax on all employers' payrolls to be paid into the fund for "sick care." Families will have the choice of which polyclinic they wish to join. The Estonians, dealing with the health care system established during the Soviet occupation, are improving it and making it work.

During the 40-year occupation of Estonia by the Russians, many citizens were sent to Siberia, but these people maintained a strong loyalty to their country and culture. They are proud and energetic and have great pride in their culture, tradition and monetary system. In fact, their monetary system maintains a relative value with other world economies, and krones must be used instead of American dollars.

The Estonians value nutrition and sanitation. They have a system of health care with universal access; employers pay and the government supports. In Estonia, laws are enforced and limits on young people are determined.

Estonia is a small country of 1.5 million people that is approximately the same as that of West Virginia. If one small country can promote prosperity and good health, perhaps one small state should look to do the same for its population.

Conclusion

The health care system in Russia, even though it offers universal access, is not effective in promoting a healthy population. The financial and political infrastructures of the country have failed to provide basic nutrition and sanitation realities, so choice has been unimportant since it has not improved quality.

While it seems essential to retain one's heritage by restoring buildings, museums and statues -- the lavish displays and money to restore buildings and the trappings of the aristocracy seem out of touch with the masses of hungry, freezing, poor people on the street and in the kiosks. Indeed, the money made by tourist attractions does not appear to return to the people.

The Russians are brave and stoic. They have survived hardship and seem to accept their lot in life with surprising equanimity and good humor. Repeatedly, we heard that the medical professionals were not making good salaries, but they liked what they were doing.

Will the stoic good humor of the Russian people persist and will they accomplish change? Will the young people, accustomed to leadership and lives planned for them, be capable of decision making? Are these youth more mature in resisting drugs, alcohol and responsible sexual activity? The Estonian rabbit shows the way; can the Russian bear do as well?

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Manuscript Guidelines

All scientific manuscripts should be submitted on an IBM compatible disc in Wordperfect 5.1 or in ASCII (generic). They must be prepared in accordance with *"Uniform Requirements for Manuscripts Submitted to Biomedical Journals."*

Papers will not be considered for publication if they have already been reported in a published paper or are described in a manuscript submitted or accepted for publication elsewhere. They should be accompanied by one extra copy, be double-spaced on white bond paper, and have the page numbers printed in the right-hand corner of each page.

All manuscripts should include:

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All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the concept.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing its most commonly known trade name.

Tables (tabular listings) and figures (photos, drawings and charts) should be numbered, and the point of reference in the text indicated in parentheses, i.e. (Table 1), (Figure 10). Photos must be unmounted glossy prints in a 5 in. x 7 in. format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be done in solid black on pure white.

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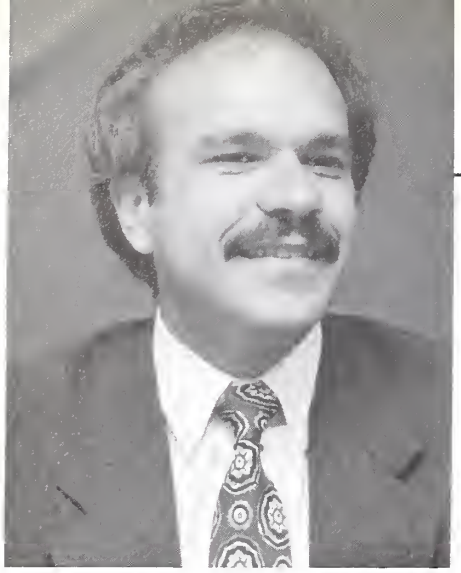

James L Comerci M.D.

Where do old presidents go?

Traditionally, the President's Page for the August *Journal* should recap the past year and highlight any successes or shortcomings (if any). While at times this year has seemed to go on forever, it truly has been very short -- just barely enough time for me to get my feet wet and begin tackling the many goals I hoped to accomplish.

I feel the details of the past year have been reported in the *Journal* and the *WESGRAM*, therefore, I would like to reflect on only a few areas of importance during the last year:

-- We now have a full staff at the office. Good morale, efficiency and excellent working relationships are evident.

-- We have continued to maintain a strong legislative presence in Charleston, as well as around the state.

-- Our CME accreditation activities have increased and continue to grow.

-- With the help of the staffs of the AMA and the WVSMA, our membership recruiting activities have increased, and the student and resident sections are growing in representation both at the state and national levels.

-- New workshops, seminars and other activities have been developed for WVSMA members. The WVSMA staff members are truly the nuts-and-bolts behind these activities.

-- Our Alliance continues to be a vital force in representation for the practice of medicine.

-- Members have dramatically doubled their contributions to WESPAC, and the WESPAC Board has been restructured to allow increased participation.

I could mention many other things, but I think the most important information you need to know from me is how I will continue to serve the WVSMA throughout the coming years. Even though I spent the two years preceding my inauguration on the Executive Committee as all presidents have, I did not actually come to realize the true needs of the WVSMA until I was president.

As I step down from this office, I assume responsibility for the Council. It is in this body of members that I feel the true strength of the WVSMA is contained. My responsibility will be to see that the Council continues to become a stronger governing body for the WVSMA.

I would like to jump start the activity of our Council. You can help by attending meetings, as well as serving as councilors, members or chairs. Our committee structure comes from the Council and must be enhanced. New ideas and the fine tuning of old ones should also come from Council members.

I feel that coordinating the Council meetings with other activities, such as committee meetings and leadership workshops for county officers, will encourage increased participation. This will provide for efficiency in time and an opportunity for networking. I also want to attempt to improve communications by providing reports which outline actions at Council meetings for each component society to review at their local meetings. In order to be effective, we must continue to expand the Council's role.

A year is only time enough to learn the job. I'm grateful to you and the WVSMA for giving me this opportunity. My only regret is that I was not able to be WVSMA president on a full-time basis and had to share this last year with my practice. I look forward to serving as chairman of your Council.

Thank you for a great year!

James L. Comerci, M.D.

James L. Comerci, M.D.

Jim will certainly be missed after he turns over the reins this month. He's been around a bit longer than most at this point. As president-elect, he spent a good part of the previous year directly involved with WVSMA affairs -- standing in for Bob Pulliam who for many months vainly occupied himself attempting to talk some sense into his colleagues in the West Virginia House of Delegates. Besides, Jim is pretty easy to get used to.

It's probably his manner that most distinguishes him. Jim is not what anyone would call pushy, just quiet and firm. Dealing with him, one quickly finds that he is not inclined to issue edicts or even engage in a lot of chit chat. He listens. He gives his ears a chance. He asks questions. He is as likely to be found talking to the little people as to the high and mighty.

Journal readers will have noted that during the past year, we have had an extremely articulate and very literate spokesman occupying our President's Page. His one overriding theme throughout the year on that page has been **ORGANIZATION.** Nothing is more important to Medicine at this time than organization at the county, state and national levels.

Because of leaders such as Jim Comerci, Medicine has probably escaped the disaster intended for it this year by the Clintons. The Clintons will hopefully go away by 1996, but the country is full of clones who will continue their socialist endeavors. Without the organization urged by Dr. Comerci, they will succeed where the Clintons have failed.

Jim is a learner -- and he is a good student. He is the first to tell anyone how much he has learned this year. We hope the WVSMA can have the benefit of his knowledge and wisdom in leadership positions for years to come.

Stephen D. Ward, M.D.
Editor

Oxymoronic

An oxymoron is a fascinating figure of speech in which contradictory terms are combined, deriving from the Greek words oxys - sharp, and moros - dull. In effect -- pointedly foolish. ***Managed care*** qualifies as an oxymoron. Real care cannot be managed.

My neighborhood service station is named ***Colonial Exxon,*** but the only colonials on the scene are the George Washington Patriots from the local high school.

Hospitals dispense memoranda headed ***Downtime Update.*** I received a letter from a consultant in which he stated he would keep me posted regarding a patient's ***recent future.***

Jumbo shrimp are advertised in restaurants. We describe interpersonal relationships as ***bittersweet,*** with ***cruel kindness*** and ***tough love.*** We discuss ***smokeless cigarettes, living wills, best educated guesses, functional limitations,*** and are often ***found missing.***

We are particularly inventive with respect to descriptions of death and dying, using euphemistic language such as ***unsuccessful resuscitation, expire quietly,*** and ***uneventful death*** to somehow modify or soften the impact. Dying abruptly and being successfully resuscitated qualifies as a state of ***post sudden death.***

Nowhere are oxymorons used as frequently as in neurological disorders. Dr. Babinski would be puzzled to read in a hospital chart that his famous sign was ***downgoing.*** Can one really have ***unsteady balance, absent reflexes, incomplete paraplegia*** and ***occluded blood flow?***

A final word concerning ***managed care***. Americans are preoccupied with the prospect of health care reform. It seems that something will be done.

Should we scrap the best existing health care system for an unproved, even untried system of government controlled ***managed care?*** How can we destroy our present health care system for one with no funding and no price tag which in essence will eliminate a trip to the office of your personal physician as an option?

Managed care is not even a ***proven hypothesis,*** but the American public is buying it with ***rampant apathy.*** Private practice, fee-for-service, primary care internal medicine cannot survive under the proposed reforms. As Yogi Berra says, "It ain't over 'til its over." It's over!

John M. Hartman, M.D.

Burton to be installed as WVSMA president

Huntington neuroradiologist Denny M. Burton, M.D., will take the presidential oath of office on Saturday, August 20, during the Second Session of the WVSMA House of Delegates at the WVSMA's 127th Annual Meeting at The Greenbrier in White Sulphur Springs.

Born in Marietta, Ohio, Dr. Burton attended Marshall University in Huntington for two years and then transferred to Duke University in Durham, N.C., where he received a B.S. degree in zoology in May 1977. He then returned to Marshall to obtain his medical degree, which he received in May 1981.

Dr. Burton completed postgraduate studies in diagnostic radiology with special competence in nuclear radiology at the West Virginia University Hospital, where he served as chief resident from July 1, 1984 - December 31, 1984. He furthered his studies as a fellow in neuroradiology at the University of Washington Hospitals in Seattle from July 1, 1985 - June 30, 1986. During his fellowship, Dr. Burton was also an acting instructor in the Department of Radiology at the University of Washington Hospitals.

Burton

Since 1986, Dr. Burton has been a clinical assistant professor of radiology at the Marshall University School of Medicine. In addition, he serves on the Marshall faculty as a clinical assistant professor in both neuroanatomy and pediatrics. At the present time, Dr. Burton is also medical director of Tri-State MRI and is a neuroradiologist for Radiology, Inc., both of which are located in Huntington.

Dr. Burton has been a member of the WVSMA Insurance Committee and the WVSMA Professional Evaluation Committee since 1988. He has served on the WVSMA Council since 1990, and in August 1992 was elected WVSMA vice president, and then president-elect in 1993. Dr. Burton is a past president of both the West Virginia Radiological Society and the Cabell County Medical Society.

Board certified by the American Board of Diagnostic Radiology, Dr. Burton is a senior member of the American Society of Neuroradiology and is a member of the AMA, the Radiologic Society of North America, the American College of Radiology, and the Roentgen Ray Society. Dr. Burton is currently the president of the Marshall University School of Medicine Alumni Association.

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Special Thanks!!!

The WVSMA staff would like to recognize the members of this year's Annual Meeting Program Committee for the effort put forth by each individual. The time and initiative taken by these members goes beyond expectations and is sincerely appreciated by the staff and all those who have the opportunity to participate in the Annual Meeting:

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Canaan Valley site for EMS directors course

The West Virginia Chapter of the American College of Emergency Physicians (WVACEP), Regional Medical Services, Inc. of Fairmont, and the Center for Rural Emergency Medicine (CREM) of WVU will be conducting the first course for medical directors in West Virginia from September 25-27 at Canaan Valley Resort and Conference Center in Davis, W.Va.

This conference is being presented for professionals who influence emergency health care, and is developed with the intent of addressing the needs of physicians who serve as EMS medical directors. Physician assistants who occasionally work with physicians to provide medical direction are also encouraged to attend.

Approved for 17.75 hours of ACEP CME credit, this course will feature lectures on "Medical Control," "Quality Assurance in EMS," "EMS Systems Management," "Emergency Medical Dispatching," "EMS Systems Design," "EMS Communications," Prehospital Ground and Air Transport," "Prehospital Personnel Education," "Mediocolegal Concerns in EMS," "Disaster Medical Services," "Prehospital Research," "Injury Control in EMS," and "Local EMS Issues."

For a brochure or registration information, contact Cathy Coster of the WVACEP at (304) 366-8764.

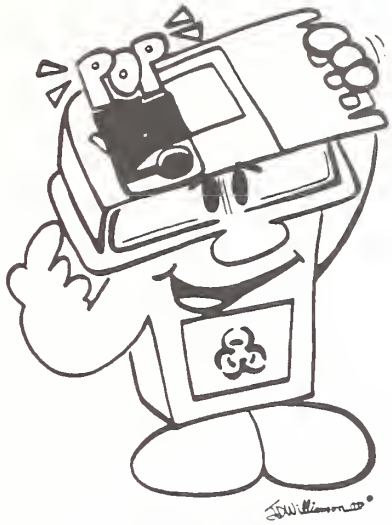
SAGES offers GI endoscopy session

The Society of American Gastrointestinal Endoscopic Surgeons (SAGES) has developed a course on *Flexible GI Endoscopy* to encourage and facilitate the practice of intraluminal (GI) endoscopy by surgeons. This seminar will be held in Cleveland on September 10-11 at the Stouffer Tower City Plaza Hotel and Mt. Sinai Medical Center Hospital.

Designed to provide a comprehensive review of diagnostic and therapeutic endoscopy with an emphasis on clinical applications and current practice trends, this program will be divided into lecture and laboratory sessions. Registration is available for the lecture only on September 10. CME credits are 6.75 hours for the lecture and 6 hours for the lab.

For additional information and registration, contact SAGES at 2716 Ocean Park Blvd., Suite 3000, Santa Monica, CA 90405, (310) 314-2404.

"No Needles" program expands statewide



"SAM THE CAN"

In September, the No Needles in the Trash Program which was started last July by Kay Lowers of the Good Samaritan Clinic in Parkersburg, will expand to 10 cities in the state.

This program provides free environmentally safe 1.7 quart containers for disposal of needles/lancets and other "sharps" used in the treatment of diabetes. Lowers created the service "to show diabetes patients they can control their diabetes and help them have and maintain a positive attitude."

Until the No Needles program was developed by Lowers, about 95 percent of sharps in the state were being thrown away with other household trash. Many patients were disposing their sharps in sealed containers, but they weren't puncture-proof. The free containers distributed by pharmacies for the No Needles program are puncture-proof, pressure-resistant, and leak-proof.

For more details, phone Lowers at (304) 428-6983.

RNSA schedules 80th scientific assembly

The 80th Scientific Assembly and Annual Meeting of the Radiological Society of North America (RSNA) will be presented Sunday, November 27, through Friday, December 2, at McCormick Place in Chicago.

The RSNA meeting is the largest medical meeting in the U.S. and the largest radiology meeting in the world. Last year, more than 54,000 health care professionals from 94 counties attended. More than 1,300 scientific papers will be presented this year -- from the latest findings about mammography to research breakthroughs in cancer treatment to new imaging techniques that avoid the need for surgery. In addition, nearly 1,500 technical and scientific exhibits will be on display.

Early registration is suggested due to limited downtown hotel space. For more details, phone 1-800-424-5249.

NRHA announces fall conference series

The National Rural Health Association has scheduled its Fall Conference Series for 1994. The series consists of three conferences designed to offer the most up-to-date information on three specific topics relating to rural health and rural health care.

The first conference is entitled *"The Ups and Downs of Rural Health Care"* and is scheduled for September 21-23 in Chester, S.C. The other two seminars will be: *"The Second Annual Conference of Rural Health Clinics,"* September 29-October 1 in Arlington, Va.; and the *"National Conference on Community Development,"* December 8-10 in Minneapolis, Minnesota.

For registration brochures, phone (816) 756-3140.

ACPE offering special health care awards

Now in its third year, the Awards Program of the American College of Physician Executives is again seeking entrants who believe they may have demonstrated a way to improve the quality of care or manage health care costs.

Entry deadline is August 31, and entry forms and instructions are available from the ACPE by calling 1-800-562-8088. ACPE is a non-profit, national organization of physicians in leadership and management positions throughout the health care field. ACPE holds a seat in the AMA House of Delegates and has over 9,000 members.

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A special word of appreciation goes to the following firms who have contributed educational grants or other support for this year's WVSMA Annual Meeting. The support given by these organizations makes possible the educational emphasis of the meeting:

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Continuing Medical Education

Listed on this page are some of the upcoming CME programs which will be held in the state. Unless otherwise noted, the events are presented at the location under which they appear.

If you would like to have the CME programs offered by your institution or association for physicians printed in the *Journal* or obtain more details about the meetings listed, please contact Nancy Hill, managing editor, at 925-0342.

Robert C. Byrd Health Sciences Center of WVU - Morgantown

August 27
"Managed Care in the 90s," The Marriott Marquis, New York, NY*

September 9
"Inaugural John E. Jones Symposium on Health Policy" (sponsored by the WVU Office of the Dean), Robert C. Byrd HSC of WVU, Morgantown

September 15-17
"20th Annual Hal Wanger Family Medicine Conference" (sponsored by the WVU Dept. of Family Medicine), Robert C. Byrd HSC of WVU, Morgantown, and MDTV sites at St. Joseph's Hospital, Buckhannon; Grant Memorial Hospital, Petersburg; Boone Memorial Hospital, Madison; Wetzel County Hospital, New Martinsville; Davis Memorial Hospital, Elkins; and Braxton County Hospital, Gassaway*

September 23-24
"The 15th Annual Clinical Ophthalmology Conference" (sponsored by WVU Dept. of Ophthalmology and the WV Academy of Ophthalmology), Lakeview Resort and Conference Center, Morgantown

October 7-8
"Pediatric Oktoberfest '94" (sponsored by the WVU Dept. of Pediatrics), Robert C. Byrd HSC of WVU, Morgantown

October 21-22
"Surgery Update" (sponsored by the WVU Dept. of Surgery and WV Chapter of the American College of Surgeons), Robert C. Byrd HSC of WVU, Morgantown

** Held in conjunction with a WVU football game*

Outreach Programs

Key to Sponsors

★ *Robert C. Byrd Health Sciences Center of WVU, Morgantown*

☐ *CAMC/Robert C. Byrd Health Sciences Center of WVU, Charleston*

Fairmont ★ Fairmont General Hospital, Oct. 4, 7:30 p.m. "Pediatric Cardiology Update," Stanley Einzig, M.D

Gassaway ☐ Braxton County Memorial Hospital, Aug. 24, 6:30 p.m.*

Lewisburg ☐ WV School of Osteopathic Medicine, Sept. 27, "Cryosurgical Ablation of the Prostate," James P. Tierney, D.O.

Man ☐ Man Appalachian Regional Hospital, Sept. 21, 6:30 p.m., "Disease of the Larynx," James T. Spencer, M.D.

Martinsburg ★ VA Medical Center, Sept. 1, 3 p.m., "Sleep Disorders," Robert Keefover, M.D.

★ VA Medical Center, Oct. 6, 3 p.m., "Acute Respiratory Failure," Harakh Dedhia, M.D.

New Martinsville ★ Wetzel County Hospital, Oct. 13, noon, "Exercise Testing for the Primary Care Physician," Anthony Morise, M.D.

★ Wetzel County Hospital, Sept. 8, noon, "Hepatitis," R. Wesley Farr, M.D.

Oak Hill ☐ Plateau Medical Center, Sept. 27, 6:30 p.m., "The Pitfalls in the Initial Evaluation of the Trauma Patient," James W. Kessel, M.D.

Point Pleasant ☐ Pleasant Valley Hospital, Aug. 25, noon, "Cryosurgical Ablation of the Prostate," James P. Tierney, D.O.

☐ Pleasant Valley Hospital, Sept. 22, noon, "Medical Emergencies," Steven Jubelirer, M.D.

White Sulphur Springs ★ The Greenbrier Clinic, Aug. 22, 4 p.m. "Prostate Cancer Prevention Trial," Unyime Nseyo, M.D.

★ The Greenbrier Clinic, Sept. 26, 4 p.m., "Breast Cancer," Edward Crowell, M.D.

★ The Greenbrier Clinic, Oct. 24, 4 p.m., "Office Practice of Sports Medicine," William Post, M.D.

** To be announced*

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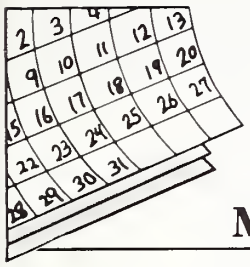


Medical Meetings

September

6-11–18th Annual Meeting of the American Academy of Neurological and Orthopaedic Surgeons, Las Vegas

8-10–Surfaces in Biomaterials Symposium (sponsored by the Surfaces in Biomaterials Foundation), Scottsdale, Ariz.

8-10–American Gynecological and Obstetrical Society, Hot Springs, Va.

10-11–Flexible GI Endoscopy (sponsored by the Society of American Gastrointestinal Endoscopic Surgeons), Cleveland

10-13–Seventh Annual Update in Internal Medicine (sponsored by Ohio State University), Columbus

11-14–American College of Emergency Physicians, Orlando, Fla.

16-17–Communication Approaches for Tracheostomized and Ventilator Dependent Patients (sponsored by Voicing!, Inc.), Louisville, Ky.

21-23–The Ups and Downs of Rural Health Care (sponsored by the National Rural Health Association), Chester, S.C.

22-23–Tools and Techniques for Improving Clinical Outcomes: A Practical Seminar for Physicians and Clinical Leaders (sponsored by the Joint Commission on Accreditation of Healthcare Organizations), Atlanta

22-24–First Annual European - American Conference on Gastrointestinal Oncology (sponsored by the George Washington University Medical Center), Bordeaux, France

22-24–American Academy of Facial Plastic and Reconstructive Surgery, San Diego

22-25–American Academy of Family Physicians, Boston

23-24–Prevention of Target Organ Damage in the Hypertensive (sponsored by Ohio State University), Columbus

23-24–Transfusion Medicine of the Future (sponsored by the American Association of Blood Banks), Phoenix, Ariz.

24-30–XIV FIGO World Congress, Montréal

25-27–Course for Medical Directors (sponsored by the WV Chapter of the American College of Emergency Physicians, Regional Medical Services, Inc., and the Center for Rural Emergency Medicine of WVU), Davis, W.Va.

28-Oct. 1–American Association for the Surgery of Trauma, San Diego

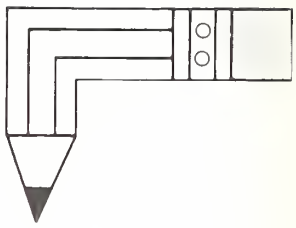
29–The Three Rs of Environmental Health: Risk, Reality and Responsibility, the National Health Council's 41st Annual National Health Forum, Washington, D.C.

29-Oct. 1–Second Annual Conference of Rural Health Clinics (sponsored by The National Rural Health Association), Arlington, Va.

For More Information . . .

Contact the Journal at (304) 925-034

Poetry Corner



A Time for Rhyme

I often regret
The passing of the time
When poems would rhyme,
And yet
Modern verse, both blank and free,
Has given me
Many hours of bliss,
(Thanks to modern poets for this).
But verses with rhymes
Recall happier times
When the world was young
And poems were sung.
There is a rhyming in God's universe
That calls to me for rhyming verse.

Robert L. Smith, M.D.

Please address your submissions for Poetry Corner to Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

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Department of Health & Human Resources

Bureau of Public Health News

This page of material is submitted and paid for by the Bureau of Public Health.

New resource guide lists opportunities for health professionals

Since West Virginia has a shortage of health care professionals, the Bureau of Public Health has developed a new resource guide on the educational and career opportunities available in the state.

Published by the Bureau's Office of Community and Rural Health Services, the *"Health Careers Reference Manual"* provides information on health care careers, as well as descriptions of occupations, their educational and training requirements, typical work activities, work settings, financial aid resources and professional contacts.

The manual is part of a long range effort to improve health care service and delivery in the state by recruiting and retaining health care professionals to work in West Virginia. More than 2,000 copies of the manual are being distributed around the state to school guidance counselors and vocational instructors. Copies are also being sent to libraries, colleges, universities, hospitals and other health care facilities in West Virginia. Publication of the manual was made possible mainly through a grant from the Claude Worthington Benedum Foundation.

To obtain a free copy of the manual, call (304) 558-3210.

Manual outlines clean indoor air policies

A manual entitled *"A Step by Step Guide for Community Tobacco Control in West Virginia"* is now available from the Bureau's Cardiovascular Disease Program to help communities pass clean indoor air regulations.

This manual provides strategies for drafting clean indoor air policies, information on assessing and building community support for such policies, and steps for ensuring the enforcement of local clean indoor air regulations.

To date, ten counties and five cities in West Virginia have already enacted clean indoor air policies, and a number of other counties are in the process of doing so. Efforts to pass these policies at the local level have been effective because residents are actively involved in promoting and enforcing the regulations.

Clean indoor air policies protect non-smokers from tobacco smoke, which has been proven to cause lung cancer and heart disease. In 1992, the U.S. Environmental Protection Agency classified second-hand smoke as a Group A carcinogen, a substance known to cause cancer. As many as 3,000 to 4,000 non-smokers are estimated to die each year in the United States from their exposure to second-hand smoke, and children exposed to second-hand smoke in the home are more likely to suffer from asthma, chronic breathing problems and ear infections.

A limited number of the free guides are available by calling Disease Prevention Director J.T. Morris at (304) 558-0644. Also at this same number, details can be obtained on implementing tobacco control policies by contacting Tobacco Control Program Director Joyce Holmes.

Provisional statistics released for 1993

The Bureau of Public Health's *"West Virginia Provisional 1993 Vital Statistics"* indicates there were fewer births, infant deaths and marriages in the state last year.

Provisional figures show there were 20,722 births to state residents in 1993, down from 22,156 in 1992. Since the surrounding states have not yet completed reports about births to West Virginians, final birth rates are expected to be slightly higher. Data also show that even though births to teenagers also fell, teen births accounted for nearly 18% of total births. In addition, the percentage of low birthweight babies remained virtually unchanged, but the percentage of women who received first trimester prenatal care decreased slightly to 75.8% in 1993, down from 76.7% in 1992.

In other vital statistics, the state's resident death rate of 11.0 per 1,000 population exceeded the 8.8 national provisional rate. Nearly 35% of all state deaths were caused by heart disease, making it once again the number one killer of West Virginians. The number of infant deaths fell to 183 in 1993, down from 201 in 1992, resulting in an infant mortality rate of 8.8 per 1,000 live births, down from 9.1 in 1992.

While the number of marriages dropped to 11,671 in 1993, down from 12,097 in 1992, the number of divorces remained nearly the same at 9,799. The marriage rate was 6.5 per 1,000 population and the state's divorce rate was 5.4 for the second year in a row.

Final vital statistics will be made available later this year. For more information, call the Health Statistics Center at (304) 558-9100.

Future Conferences

WV Public Health Association
"Public Health Reform: Making It Happen"

September 21-23
Parkersburg Holiday Inn
Parkersburg, WV

For more information call:
Karen Hall-Dundas - (304) 523-6483

WV Conference on Emergency Medical Services
"Wild, Wild West"

September 27-28
Canaan Valley Resort
Davis, WV

For more information call:
Carlo Zando - (304) 558-3956

WV Rural Health Conference
"Transitions in Rural Health Care: Successful Survival Strategies"

November 4-6
Lakeview Resort
Morgantown, WV

For more information call:
Tera Thomas - (304) 558-1327

ROBERT C. BYRD HEALTH SCIENCES CENTER
OF WEST VIRGINIA UNIVERSITY

Compiled from material furnished by the Robert C. Byrd Health Sciences Center of West Virginia University, Communications Division, Morgantown

OB/GYN Department to create tumor bank, affiliate with GOG, NCI

The Department of OB/GYN's gynecologic oncology division will establish a gynecologic tumor bank and affiliate WVU with the Gynecologic Oncology Group and the National Cancer Institute.

The bank will be headed by Dr. R. Gerald Pretorius, associate professor and director of gynecologic oncology, and Dr. Andrew Patrick Soisson, who joined the department in July.

Dr. Soisson comes to WVU from the gynecologic oncology division at William Beumont Army Medical Center in El Paso, Texas. He earned his medical degree from Georgetown University and completed a residency in OB/GYN at Madigan Army Medical Center in Tacoma, Wash. Dr. Soisson completed his oncology training at Duke University Medical Center.

Grant helps establish Health Sciences and Technology Academy

The HSC's Office for Social Justice received a five-year, $175,000 grant from the Howard Hughes Medical Institute to establish a Health Sciences and Technology Academy (HSTA).

The academy will encourage pre-college minority and financially disadvantaged students to enter careers in the health sciences. "These are two groups that need better representation in the health care professions," says Ann Chester, Ph.D., assistant to the vice president for health sciences for social justice and HSTA project director. "They are also two groups we believe are highly likely to go back to their communities to work as health care professionals."

For more information on HSTA, call 1-800-345-4267 or (304) 293-2895.

Hill named chair of WVU review board

Hill

Dr. Ronald Hill, professor of cardiothoracic surgery, has been named chair of the WVU Institutional Review Board (IRB) for the Protection of Human Research Subjects.

Dr. Hill has served on the IRB since 1990. He succeeds Dr. Irma Ullrich, professor of endocrinoogy/metabolism, who stepped down after serving as chair of the board for four years.

Pearson lectures at Romanian conference

Pearson

R. John Pearson, M.B., M.P.H., professor and chair of community medicine, recently discussed health care in West Virginia for his keynote address at the annual meeting of the School of Public Health in Iasi, Romania.

Dr. Pearson was the first Westerner in 45 years to speak at this institution, and he will serve on the editorial board of the school's *Journal of Preventive Medicine*.

Kolbenschlag writes book on gender issues

Madonna Kolbenschlag, Ph.D., clinical psychologist for University Health Service, recently traveled to Spain to launch the world-wide publication of her book *Kiss Sleeping Beauty Good-By*.

Dr. Kolbenschlag's book, which will be published in five languages, is on women's psychology and gender issues.

Hornsby elected to ADA board of directors

Hornsby

W. Guyton Hornsby, Ph.D., assistant professor in the exercise physiology program of the Department of Medicine, has been elected to a three-year term on the American Diabetes Association Board of Directors.

Dr. Hornsby has been actively involved in the ADA for many years. He has been instrumental in advancing the use of exercise in diabetes care.

Ramadan presents two papers at seminar

Ramadan

Dr. Hassan Ramadan, assistant professor of otolaryngology, recently presented two papers at a meeting of the American Rhinologic Society in Palm Beach, Fla.

The two papers were *"Bacteriology of Chronic Sinusitis in Adults,"* and *"Endoscopic Treatment of Acute Frontal Sinusitis."*

Williams, Heimbach author BTLS chapters

Dr. Janet Williams, assistant professor of emergency medicine, and research director for the Center for Rural Emergency Medicine, and Leah Heimbach, CREM administrator, have written chapters in the *Basic Trauma Life Support Advanced Prehospital Care* textbook.

Dr. Williams' chapter is entitled *"Injury Prevention and Control and the Role of the Prehospital Healthcare Provider."* Heimbach's chapters are *"Trauma in the Elderly"* and *"Trauma Scoring in the Prehospital Setting."*

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Marshall University School of Medicine

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Master's degree in forensic science to be offered at Marshall

The state's first degree program in forensic science -- and one of only about seven master's-level programs in the country, will begin at Marshall in the fall of 1995, according to Dr. Terry Fenger, acting chairman of the Department of Microbiology, Immunology and Molecular Genetics.

The new graduate program in forensic science is based on molecular biology and the latest techniques in DNA typing. It was approved by the state board of trustees in July.

Dr. Fenger said that Marshall's degree program will be unique since only a few of the 17 established forensic programs in the country are master's level, and few, if any, focus on molecular biology and DNA typing. "West Virginia has the potential of being a leader in the development and use of DNA technologies for forensic purposes," he said.

The School of Medicine's forensic science division, which Dr. Fenger heads, has been offering continuing education classes and performing forensic work for the state police for more than two years. A special $100,000 state appropriation will help develop the program further.

The division is the first stage in the development of Center for Applied Biotechnology which will be directed by Dr. L. Howard Aulick, assistant dean for research development. In addition to forensic science, the center will include a medical sciences division and an environmental science division, Dr. Aulick said. He is currently looking for a suitable facility to house laboratories and equipment.

"We hope to collect in one facility a basic set of molecular equipment and to apply that core equipment to forensics, environmental science and medical diagnosis," Aulick said. All three areas utilize similar DNA techniques.

The forensics program will feature a state-of-the art DNA typing facility with a cell molecular laboratory designed to support the accelerating demands of law enforcement agencies and the court systems for identity testing. It will also serve as a training center for the master's degree program. Plans call for using the laboratory to research new DNA typing techniques as well. Dr. Fenger said that the forensic program will use existing facilities on the main campus and at the School of Medicine for now, but will need additional laboratory space to expand into the research area.

The medical sciences division, which will be directed by Dr. Richard Niles, chairman of the Department ofBiochemistry and Molecular Biology, will feature an Advanced Medical Diagnostics Laboratory as an extension of the DNA typing facility. It will provide both DNA-based and non-DNA-based clinical diagnostics, emphasizing assays for cancer, infectious diseases and genetic diseases. Only those educational, research and clinical services not available at existing local medical facilities will be offered.

A market survey being developed by the College of Business will determine what advanced diagnostic tests are needed locally. "Instead of sending to New Jersey for these tests, hospitals will be able to have them performed right here," Dr. Aulick said.

The medical sciences division will also provide training in advanced DNA protocols for MU clinicians and conduct research on new diagnostic tests. "Dr. Niles is interested in and committed to bringing biotechnology and the biotechnology industry to Huntington," Dr. Aulick remarked.

Other research planned for the center would explore the genetic basis for diseases common in West Virginia, such as hypertension, obesity and cancer. Dr. Aulick pointed out that such research ties into the school's rural health initiative and could build on groundwork already laid in places like Lincoln County. The environmental science division will focus its research on environmental assessment and reclamation, he added.

Study shows dramatic economic impact of health care in Tri-State

A new Marshall University study released by MU President J. Wade Gilley indicates that the health care industry's economic impact on the Tri-State area amounts to more than $1.1 billion annually and 27,000 jobs.

The study was headed by Marshall's Distinguished Professor of Management Robert P. Alexander and funded by the Marshall's Research and Economic Development Center. It covers Cabell and Wayne Counties in West Virginia, Lawrence County in Ohio, and Boyd, Greenup and Lawrence counties in Kentucky.

Direct expenditures by the health care industry totaled $642,247,600. Applying the standard multiplier effect resulting from respending of these dollars, the total economic impact was $1,104,665,900, Alexander said. Health care provided 11,767 jobs directly with secondary jobs bringing the total to 27,488, generating household incomes amounting to $505,641,500.

MU's practice group adopts new name

Marshall physicians have changed the name of their practice group to University Physicians and Surgeons.

The new name, which replaces the name John Marshall Medical Services, provides a common thread that will make it easier to recognize the many area offices in which faculty members treat patients, said James Schneider, the school's associate dean for finance and administration.

With University Physicians and Surgeons as the umbrella organization, offices run by individual departments will use variations such as University Pediatrics and University Family Physicians.

"We would like to create a more unified public image for our clinical departments before we make our proposed move into consolidated facilities," Schneider said.

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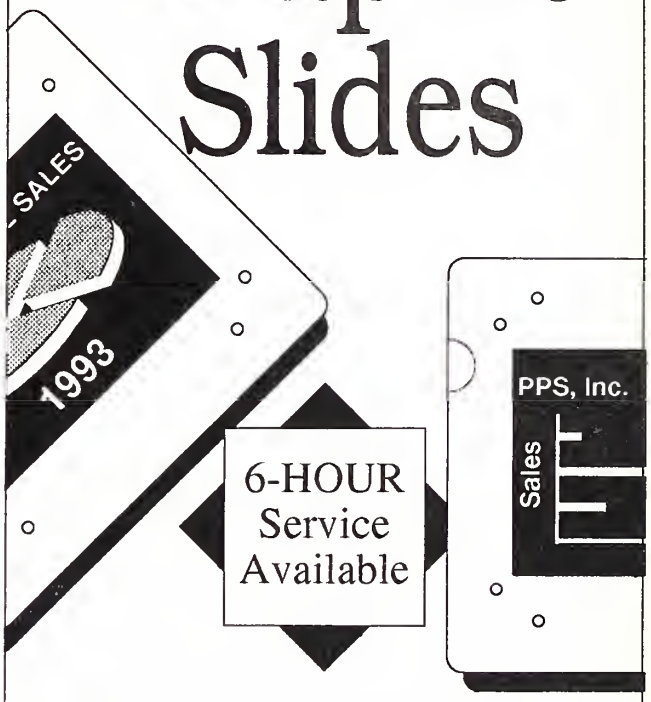

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Alliance News

Farewell message

Do you know what was great about being the president of the West Virginia State Medical Association Alliance? Everything! There were places to go, people to meet, and things to do all over the state -- and all the experiences were a pleasure.

Dr. Jim Comerci and I tried to visit most of the counties in the fall to have the opportunity to meet members, as well as promote the Alliance and the WVSMA. Two workshops were presented in September by AMA Alliance Field Director Ann Wrenn. One workshop was held in Morgantown, and the other was in Charleston. We learned about membership promotion, and Ruth Gilbert gave a minicourse on parliamentary procedure.

During the past year, I represented the Alliance at several national conferences which were educational and motivational:

1. The AMA National Political Education Conference in Washington, D.C. - Sept. 29-30.

2. Confluence in Chicago - Oct. 3-5.

3. Southern Medical Convention in New Orleans - Oct. 28-31

4. AMA Alliance National Convention in Chicago - June 12-14.

AMPAC has always promoted their Campaign Management School. In March, I spent a week in Washington, D.C., attending the school. I presented an article in the April issue of the *West Virginia Medical Journal,* which gave my account of the most extraordinary week of my life. Read it before you plan to attend the school.

The Fall Board Meeting at Hawks Nest State Park, and the Spring Board Meeting at the Days Inn in Flatwoods, were well attended. These places were ideal for meetings, and we received royal treatment.

Many counties produced health projects that benefited their counties. I would still encourage the county health chairmen to contact their local health departments to help solve the needs in their communities.

The WVSMAA became a member of the West Virginia Tobacco Control Coalition this year. There are 60 organizations who belong to this coalition. They were impressed with our lobbying skills and the legislative phone bank that we used in promoting health legislation this year.

It has been a pleasure to work with the staff at the the WVSMA. They all were available at a moment's notice to answer any question. They made me feel comfortable with their friendly dispositions and smiling faces. I could tell they all like their jobs and take pride in their work. There is a definite atmosphere of cooperation.

Special thanks to Winnie Morano, who serves as the WVSMAA executive secretary and director of government relations. She helped reorganize WESPAC, writes and edits *WESGRAM,* the *Legislative Update,* and *MedLink.* She does a great job in all these areas. If I had not had Winnie to help me, I would not have been able to accomplish my goals.

I attended all the WVSMA's Council meetings this year. It was an honor to be allowed to have a vote at these meetings, but I also appreciated being asked to give my opinion during various discussions.

WVSMA President Dr. Jim Comerci, with his calm, hardworking style, was always interested in what was being done in the Alliance. He always made me feel as though the WVSMA and WVSMAA are partners working to make West Virginia a better place to work and live.

I want to also thank all my officers and board members. It is wonderful to have people who know their jobs and do them well. Without a doubt, I feel as though I have been the president of the best organization in the state because of the superior quality of the members of the WVSMA Alliance.

Carole Scaring
WVSMAA President, 1993-94

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Front Cover

Bees make their nightly visit to a *datura* flower in the garden of Paul and Nancy Hill of Charleston. Photo courtesy of Nancy Hill, managing editor of the *West Virginia Medical Journal.*

Lessons from the Swedish health care system

BRIAN J. CAVENEY
Accepted to West Virginia University Medical School, Morgantown

Editor's Note: Brian Caveney recently visited Sweden for 16 days with a group of U.S. health care professionals and government leaders to study the country's health care system. In 1991, he visited China to observe traditional Chinese medicine, and that same year he was also selected by USA TODAY as one of 20 academic All Americans.

Sweden's nationally-controlled system of health care has often been envied by other countries and touted as a possible option to our current system in the United States. However, during the past decade many major problems have arisen with the delivery of health care in Sweden, and multi-level reforms have been introduced in an attempt to improve the system's efficiency and quality. Even with these reforms, though, Sweden's system of health care is not an option in the United States for many reasons.

The Swedish health care system was founded on a needs-based, command-and-control model in which national and regional government planners allocated money and personnel according to demographic and epidemiological patterns. The system has traditionally operated under the fundamental principle that all citizens deserve equal access to health and medical care. Responsibility for care has been the duty of 23 county councils and accounts for 75%-80% of the total expenditure of most county councils.

The quality of care in Sweden has not been comprehensively measured, but the health of the population is relatively good by international standards. The infant mortality rate is the world's lowest and its life expectancy rate is the highest (1). Over the years, though, the need for progressive reforms has been dramatic due to the aging of the country's citizens, expensive technological improvements and constrained public sector budgets. In addition, other major problems exist with the system because of its lack of freedom of choice for the patients; its inaccessibility to primary health care; its low productivity because of a lack of incentives and conflicting roles; and its lack of quality control and monitoring (2). The Swedish Institute also considers other problems inherent with the system such as long waiting lists for certain procedures, lack of integration between certain divisions of the social insurance organization; and a faulty primary care system with a high proportion of direct referrals to hospitals (1).

In an article entitled *"Towards a Swedish Health Policy for the 1990s: Planned Markets and Public Firms,"* Otter and Saltman made the point that the Swedish system was unable to meet the fundamental needs of the patient in spite of sufficient funding (3). Otter and Saltman also stated that uninformed politicians should allow the organization of operational activities to be the responsibility of health care professionals. In addition, the Swedish Institute also faulted the system for not having any measures in place for evaluation of services (1).

The necessity for reform was a political consensus that was recognized in the late 1980s, but the first major actions were not introduced until 1992. The Public Health and Medical Service Committee of the Stockholm County Council released a leaflet called "The Stockholm Model" which decribed these new organizational and theoretical principles (4).

The key attribute of this model was the placement of the patient at the center, which significantly increased the rights of the patient. This new mandate gave patients the freedom to choose their family doctor, their health clinic, specialists and hospital, whereas, previously patients were assigned to sites in their immediate geographical area. In addition, the Stockholm Model stated that no one was to wait more than three months for certain surgical procedures; the number of family doctors was to be increased so on-call service could be offered; patients did not have to pay more than 1,600 Swedish crowns (about $200) in health care costs in one year; medical audits were to be installed to insure quality care; and patients were given the right to legally appeal any treatments they considered improper.

These many reform elements were implemented under the premise of equality in health care, a longer and healthier life, and equal access to high quality care (4). According to Thorslund, "Sweden will remain a welfare state, but the fundamental commitment to universalism will be diluted and selectivity will creep in" (5).

In an interview on June 16, 1993, Jan-Ake Andren of the Stockholm County Council Health and Medical Care Unit stated that the measures taken in the Stockholm Model were designed to save money by increasing productivity, by placing age limits and priorities on certain procedures, by raising the amount of fees covered by the patient, and by exploring private insurance and financing to make up further discrepancies. He stated that these actions showed that their nationalized system raised the patients' medical care costs through taxes and lowered the number of services available -- an outcome which American physicians fear would be the result of nationalized care in the U.S.

The short-term consequences of the reforms in Stockholm County did provide support for patient choice. Currently, all individuals can pursue alternative treatment sites if they desire. For example, 15% of Sweden's expectant mothers select a hospital other than the one in the geographical area to which they would previously have been assigned. This fact has encouraged maternity wards to offer different techniques for childbirth that are more popular with women -- a change which has actually improved the coordination between clinics and maternity primary care offices, according to Otter and Saltman (3).

The problems that triggered some of the reforms in the Stockholm Model

serve to indicate that similiar or more severe problems would arise if the original plan proposed by President Clinton or the current Mitchell proposal were enacted. First and foremost, certain aspects of Swedish society have a major impact on the management and delivery of health care. Reliance on the government for support in a society built on the honor system is certainly contrary to the individualistic "every man for himself" attitude fostered in our own society. The Swedish mindset expects cradle-to-grave amenities from its socialized system. Otter and Saltman suggest that under the pre-reform organization, there existed a social democratic concept of equity within welfare state distributions that expected the individual to place his needs in a collective way of thinking, thus creating a degree of classlessness (3).

These socialistic perspectives, while inherently present in the Swedish people, would be logistically impossible to adopt in American society. Swedish society enthusiastically has given priority to the country's goals of reducing the number of smokers by half, reducing the consumption of fat by one-fourth, reducing the consumption of alcohol by one-fourth, and reducing the number of accidents from environmental and living habits (4). These public health goals are often discussed in the United States, but in no way are they given the attention and prominence they are in Sweden.

In the United States, the high cost of health care is due to many factors, but one of the main reasons is that we tend to eliminate the conflicts between medical ethics and financial demands by opting for continued care and services. In fact, it has been claimed that 40% of an American person's lifetime health care budget is spent during the last 90 days of his/her life. This reality is also one of the reasons that promoted the need for reform of the Swedish system since it has one of the highest proportions of elderly people in the world, with 18% of its citizens over the age of 65.

Thorslund (4) has recommended that guidelines be set for limiting the use of technology in situations where it is unlikely to be of benefit. This priority setting and use of age limits would probably not be tolerated in America, where increased value is placed on the last moments of life without regard for cost. As George Church noted in an article for *Time* (6), "Luxury care will become very rare, since almost no coverage will pay for it."

Another difference between the United States and Sweden is the incidence of litigation. According to an 1993 article by Fields published in *Insight* (7), the total expenditure for malpractice insurance in the United States was $7 billion in 1988, and estimates indicate that one in 25 doctors is successfully sued every year. Even though Senator Rockefeller claims that malpractice only accounts for 2% of the total costs incurred, other intrinsic factors such as defensive medicine greatly increase the occurrence of unnecessary procedures and reluctance to treat potentially litigious patients.

"Right now I'd rather be in Sweden than in the U.S. because we are moving away from the welfare state. On your side, you are moving right into it, and you risk destroying your country" (8).

This malpractice situation is almost non-existent in Sweden because traditionally patients do not question the knowledge and expertise of their practitioners. As a result, costs do not increase because of patients soliciting second, third and fourth opinions. Since the exact opposite is true in the U.S., it is very obvious that no effective cost containment is possible without serious restructuring of tort procedures and limitations on contingency fees. Fields implores that we should expect lawyers to abide by ethical premises like those stated in the Hippocratic Oath with the same fervor and conviction expected from doctors (7).

Possibly as a result of American influence, the reforms in the new Stockholm Model granted patients the right to complain and appeal about problems to a patient ombudsman at a hospital, a county council representative board, or a health care disciplinary board. This is just one of several measures that indicate movement toward the outlines of the traditional American system of health care.

Other Swedish reforms intentionally emulate various aspects of the market system with built-in incentives for the providers as well as the recipients. The Stockholm Model exceeds a basic premise of fee for service and approaches a system of fee for proven results. The resulting trend is for reimbursement to be provided by personal income financing rather than government subsidy. This incentive has already increased productivity by 8% during 1992, while it reduced surgery waiting lines and times by as much as 45%. For example, between 1990 and 1992, cataract operations increased by 220% and hip/knee replacements by 80% (3).

While progressive reforms are underway in Sweden, the push to reform health care in this country continues to the disbelief of many Swedes. Ian Wachtmeister, head of the New Democracy Party which has recently been elected into office, said "Right now I'd rather be in Sweden than in the U.S. because we are moving away from the welfare state. On your side, you are moving right into it, and you risk destroying your country" (8).

After observing the Swedish system firsthand, I understand how important Wachtmeister's statement needs to be to U.S. leaders and citizens. Even the writers of the Swedish reforms acknowledge, on top of all the other problems I have mentioned, that nationalized health care has also caused their country to neglect research and teaching, and create a large and inefficient bureaucracy. As Otter and Saltman have said, care must also be given to establish the differences between a commercial commodity and a professional service such as public health (3).

In closing, I hope that if any reforms are made in the U.S., our government leaders take into account a few maxims learned in every introductory course in economics: there is no such thing as a free lunch -- government is never as efficient at the allocation of resources as the private sector -- and price controls always lead to less of the controlled commodity.

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West Virginia Physicians: Cardiovascular risk factors, lifestyles and prescribing habits

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Abstract

Physicians educate their patients by direct teaching and by serving as a role model. Through the use of questionnaires, we evaluated the degree to which physicians in West Virginia participate in these activities. Thirty-five percent of the 2,404 licensed physicians in the state returned completed questionnaires. Although 90% prescribed appropriate diets and recommended exercise for their patients, the physicians who responded were often less likely to follow their own advice. Twenty percent of the male physicians and 13% of the female doctors were obese; 30% had LDL cholesterol levels over 130 mg./dl.; 13% had HDL cholesterol values of less than 35 mg./dl.; and 8% had triglycerides over 250 mg./dl. Participation in regular exercise (30 minutes three times per week) was reported by 48% of the male physicians and 47% of the female physicians. Eight percent of the men were smokers, as were 1.9% of the females. These results suggest that the role model aspect of patient education may need to be improved among some West Virginia physicians. It is an inexpensive method of directing attention to lifestyle in order to decrease preventable disorders such as coronary artery disease, obesity, diabetes, and hypertension.

Introduction

Many medical disorders such as coronary artery disease, diabetes, obesity, and hypertension are greatly influenced by lifestyle factors such as diet, inactivity, and smoking. In states like West Virginia, in which these disorders rank among the highest in the nation (1), it is particularly important to direct attention to preventive lifestyle measures such as proper nutrition, exercise, and smoking cessation. These preventive measures are also much less expensive than in-hospital care.

Physicians, because of their different specialties, are involved in education regarding healthy lifestyles to varying degrees. Although in some medical specialties such as pathology, physicians may have little opportunity for educating patients directly, they may still serve as examples in the community for appropriate behaviors. This is especially true in a rural area where the physician may be a leader in the community.

Several recent studies have shown that medical students and physicians are not living healthy lifestyles themselves. At the West Virginia University School of Medicine, research has shown that many second-year medical students were at increased risk of developing cardiovascular disease due to inactivity, hypertension, hyperlipidemia, and stress (2). At Temple University Medical Center, a questionnaire revealed that physician behaviors with respect to preventive health practices such as alcohol use, sleep, exercise, smoking, and obesity were not substantially different from those of the general population (3). In addition, a study of physical activity among physicians in Saskatoon, Saskatchewan determined that of the 210 physicians responding to a questionnaire, only 30% were considered to be physically active (4). This was less than the general Canadian population. These physicians did, however, believe that exercise was important to them personally and that patients should be informed of the benefits of physical activity.

In an editorial concerning physicians, Shangold (5) remarked that "The medical profession has created a large credibility gap with the general population by the failure of its members to practice what they preach." In a position statement regarding physical activity for all Americans, Fletcher and colleagues (6) stated "Physicians have the opportunity and responsibility to promote regular exercise as well as the reduction of high blood pressure, management of abnormal blood lipids, and prevention and cessation of smoking."

Physicians have a dual role in promoting lifestyle changes among their patients by serving as both role models and educators. Since the degree to which these roles are practiced by West Virginia physicians was unknown, we decided to examine the following two questions:

1) The incidence rates in West Virginia physicians for several heart disease risk factors; and
2) The frequency with which these physicians counseled their patients regarding diet and exercise.

Methods

A questionnaire was designed to evaluate various risk factors for coronary artery disease and the prescribing habits of physicians. This survey and a cover letter explaining its purpose were mailed to all physicians who were members of the West Virginia State Medical Association residing in West Virginia. Another mailing was sent six weeks later to the physicians who had not responded initially. Of the 2,404 available subjects, 834 (35%) returned completed questionnaires.

The questionnaire requested information concerning height, weight, blood pressure, blood lipid values, smoking, diabetes, and personal and family history of heart disease. Leisure time physical activity was categorized into moderate activity such as brisk walking, hard acuivity such as half-court basketball or scrubbing floors, and very hard activity (shoveling snow or running). Subjects were asked to indicate their level of stress on a scale of 1 to 10, with 1 being no stress and 10 indicating severe stress. Work and leisure time stress levels were rated.

Patient education was evaluated with a question which asked about the prescription of exercise to

patients. Another question asked whether nutritional counseling was provided "always," "sometimes," or "never." Data was analyzed according to gender and the following medical specialties: internal medicine, family practice, surgery, pediatrics, and other. The individuals who practiced pathology, psychiatry, radiology, anesthesiology, and all other specialties not included in the first four groups were included as other.

Results

There were 208 physicians (23.9%) classified as internal medicine specialists, 155 (17.8%) as family practitioners, 225 (25.8%) as surgeons, 54 (6.2%) as pediatricians, and 192 (22%) as other specialists. The mean age of the respondents was 50 years with no differences among specialties; 12.9% were women. Overall, 86.4% of the physicians surveyed reported they were currently married; 84.4% were Caucasian.

Several characteristics of the physicians are listed in Table 1. The body mass index (weight in kilograms ÷ height^2 in meters) is a measure of body fatness. The mean BMI was in a desirable range for all groups, but 20% of the males and 13% of the females were obese. Reported mean resting blood pressure was well within the normal range, although, some physicians were taking antihypertensive medications (Tables 2,3).

Mean lipid values (total cholesterol, LDL and HDL cholesterol, and triglycerides) for all specialty groups were within the range recommended by the National Committee for Cholesterol Education Program (7). However, 30% had LDL cholesterol levels over 130 mg./dl., 13% had HDL cholesterol levels less than 35 mg./dl., and 8% had triglycerides over 250 mg./dl.

As expected, less stress was noted in leisure times compared to work with little difference noted among specialties or gender. Thirteen percent of the male physicians reported existing heart disease, while only 7.5% of the female physicians reported it. More males (15%) than females (6%) used antihypertensive medicines. Tables 2 and 3 list other characteristics by gender and specialty. Eight percent of the male physicians and 1.9 percent of the female physicians were smokers; pediatricians were more likely to be smokers than other specialists.

Diabetes was present in 3% of the male physicians and 68% of these individuals had non-insulin dependent diabetes. One female physician reported type II diabetes.

Men reported regular exercise (a minimum of 30 minutes per session, three times weekly) 48% of the time as compared to 47% of the women. Male pediatricians and female family practitioners were the least likely to participate in regular exercise.

Table 4 lists answers to questions regarding prescription of exercise and provision of nutrition counseling. More than 90 percent of both male and female physicians prescribed exercise

Table 1. Personal Health Characteristics of the Male and Female Physicians Surveyed

	Internal Medicine	Family Practice	Surgery	Pediatrics	Other
Age	49±15*	51±16	51±13	48±15	49±13
Body Mass Index	24±4	24±4	25±4	24±5	24±4
Resting Blood Pressure (mmHg)	120/75	125/78	122/76	120/74	120/75
Cholesterol, Total (mg./dl.)	192	193	194	191	193
Cholesterol, HDL (mg./dl.)	51	51	53	58	53
Cholesterol, LDL (mg./dl.)	124	127	118	125	124
Triglycerides (mg/dl)	131	135	137	102	163
Work Stress	6.1	6.1	6.1	6.2	6.2
Leisure Time Stress	3.3	3.4	3.3	3.4	3.1

* Mean Values

Table 2. The Female Physicians' Rates of Heart Disease, Smoking, Diabetes and Exercise

Specialties	Internal Medicine	Family Practice	Surgery	Pediatrics	Other
Number	22	16	21	20	29
Known Heart Disease					
Yes	0	1 (6%)	2 (10%)	2 (10%)	3 (10%)
No	21 (100%)	15 (94%)	19 (90%)	17 (90%)	26 (90%)
Using Antihypertensives					
Yes	0	2 (12%)	0	2 (10%)	2 (7%)
No	22 (100%)	14 (88%)	21 (100%)	18 (90%)	27 (93%)
Smokers					
Yes	0	0	0	1 (5%)	1 (3%)
No	22 (100%)	16 (100%)	21 (100%)	19 (95%)	28 (97%)
Diabetes					
Yes	0	0	0	1 (5%)	0
No	22 (100%)	16 (100%)	21 (100%)	19 (95%)	29 (100%)
Exercise					
Yes	10 (45%)	6 (37%)	12 (57%)	10 (50%)	13 (45%)
No	12 (55%)	10 (63%)	9 (43%)	10 (50%)	16 (55%)

Table 3. The Male Physicians' Rates of Heart Disease, Smoking, Diabetes and Exercise

Specialties	Internal Medicine	Family Practice	Surgery	Pediatrics	Other
Number	186	139	204	34	163
Known Heart Disease					
Yes	21 (11%)	23 (16%)	23 (12%)	2 (6%)	23 (14%)
No	163 (89%)	116 (84%)	174 (88%)	31 (94%)	139 (86%)
Using Antihypertensives					
Yes	21 (11%)	23 (16%)	35 (17%)	3 (9%)	25 (15%)
No	162 (89%)	116 (84%)	165 (83%)	31 (91%)	136 (85%)
Smokers					
Yes	11 (6%)	10 (7%)	23 (11%)	4 (12%)	10 (6%)
No	174 (94%)	129 (93%)	179 (89%)	30 (88%)	153 (94%)
Diabetes					
Yes	6 (3%)	4 (3%)	3 (2%)	1 (3%)	8 (5%)
No	178 (97%)	135 (97%)	199 (98%)	32 (97%)	155 (95%)
Exercise					
Yes	93 (51%)	60 (43%)	101 (51%)	10 (29%)	79 (49%)
No	90 (49%)	79 (57%)	98 (49%)	24 (71%)	82 (51%)

either always or sometimes. Likewise, 90% of all physicians reported that they provided nutritional counseling either always or sometimes.

Discussion

Physician behavior can make as important a contribution to patient education about a healthy lifestyle as does what is taught directly. This study has examined by questionnaire the behavior of West Virginia physicians. Although over 90% of responding physicians said they prescribed both exercise and proper nutrition to their patients, they were less diligent in following their own advice. Less than half of those surveyed exercised the recommended 30 minutes three times weekly. Twenty percent of the male and 13% of the female physicians were obese. Several physicians were smokers.

The incidence of existing heart disease of only 13% in the men and 7.5% in the women, may reflect their higher socio-economic status. This has been reported previously in a large group of male physicians who participated in the Physicians' Health Study (8). The relatively young age (a mean of 50 years) of the respondents may also be important.

Diabetes and hypertension are important risk factors for coronary artery disease which may also be modified by diet and exercise. Diabetes was reported in only three percent of the physicians in our studies. It is not known whether all of those with type II diabetes were obese. Epidemiologic studies (9) have shown that hypertension, obesity, and inactivity, as well as a positive family history are important predictors of diabetes. Conversely, even in those with a positive family history, avoidance of obesity and performance of routine exercise may prevent diabetes. These factors may be especially important in West Virginia which has one of the highest rates of diabetes in the United States.

Hypertension was present in up to 15% of the male physicians and is likely multifactorial in origin. It should be recalled that exercise may serve as both prevention as well as therapy for hypertension (10).

Many medical schools, including those in West Virginia, have only recently added nutrition education to their curriculum. Family practice residences have required such education since 1983 (11), but many of the physicians we surveyed would have completed their formal training prior to this time. There continues to be a lack of instruction on the appropriate use of exercise as a therapeutic modality. Because of an initial increase in mortality with heavy exertion (12), caution must be used when prescribing exercise to a sedentary individual.

Table 4. The Tendencies of Both Male and Female Physicians to Prescribe Exercise and Provide Nutritional Counseling

MALES	Internal Medicine	Family Practice	Surgery	Pediatrics	Other
Prescribe Exercise					
Always	69 (40%)	53 (42%)	59 (32%)	9 (28%)	27 (24%)
Sometimes	95 (55%)	74 (58%)	115 (62%)	21 (66%)	70 (61%)
Never	10 (6%)		12 (7%)	2 (6%)	18 (16%)
Provide Nutritional Counseling					
Always	58 (34%)	37 (29%)	24 (13%)	8 (25%)	12 (10%)
Sometimes	107 (62%)	89 (71%)	137 (73%)	23 (72%)	74 (64%)
Never	8 (5%)		26 (14%)	1 (3%)	29 (25%)
FEMALES					
Prescribe Exercise					
Always	13 (59%)	10 (67%)	5 (24%)	7 (37%)	8 (42%)
Sometimes	8 (36%)	5 (33%)	14 (67%)	12 (63%)	6 (32%)
Never	1 (5%)		2 (10%)		5 (26%)
Provide Nutritional Counseling					
Always	9 (41%)	8 (53%)	7 (33%)	7 (37%)	5 (26%)
Sometimes	12 (55%)	7 (47%)	11 (52%)	12 (63%)	9 (47%)
Never	1 (5%)		3 (14%)		5 (26%)

The response rate of 35%, while better than the 10% response to most questionnaires, is a major limitation of our study. The relatively small numbers in some specialties such as pediatrics, makes observations less reliable. Women physicians represented only 13% of the total responders which may underrepresent their total involvement in the care of West Virginians. Some specialists have limited contact with patients, therefore, the questions relating to giving advice to patients has little meaning.

It appears from the results of this survey that West Virginia physicians are active in giving nutritional advice and prescribing exercise to their patients. However, there is room for improvement in the role model aspect of physician behavior. Those physicians who are smokers would be best advised to discontinue this habit for their own health as well as to enhance their credibility as health experts. Those physicians who are obese and sedentary may be less than convincing to their patients when they give advise on diet and exercise. The role model aspect of patient education is inexpensive and may be particularly important in a rural community.

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A study of helicobacter-pylori in 100 pediatric patients from the Tri-State area

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Abstract

Helicobacter pylori (HP) is a newly discovered pathogen implicated in the pathophysiology of peptic ulcer disease. The aim of this study was to review all pediatric patients who were evaluated by upper endoscopy through the Pediatric Gastroenterology Service at the Marshall University School of Medicine between July 1990 and March 1993. A total of 100 charts were retrospectively reviewed. HP was diagnosed by CLO-test and confirmed histologically. Results showed that the major presenting symptom was abdominal pain (53%). GI mucosal inflammation was found in 77 patients, and 41% of these cases were associated with HP. Two patients had duodenal ulcer; both were HP+. The incidence of gastritis was significantly higher in patients with HP+ compared to HP-. Follow-up on the HP-associated gastritis showed no significant difference in their clinical response irrespective to the treatment, we conclude that HP in children is highly associated with gastritis, but not duodenitis or esophagitis; and in our experience, that CLO has a high failure rate in identifying HP in the mucosa.

Introduction

Helicobacter pylori (HP), a gram-negative, motile, spiral-shaped bacterium was discovered in 1983 by Warren and Marshall (1). HP has been recently recognized as the most prevalent cause of chronic gastritis in adults (2,3) and children (4,5). Studies have also demonstrated that almost all primary duodenal ulcer disease is related to HP (3,5).

The prevalence of HP infection among asymptomatic adults and children has been shown to increase with age (6,7,8). In adults, HP has been associated with approximately 92% of duodenal ulcers and 70% of gastric ulcers (9,10). In children, the presence of HP is associated with gastritis (11,12) and possibly with duodenal ulcer (13,14). Although data on HP in children is limited, it is suggested that the incidence of HP in the pediatric population is lower than that seen in the adult population (4,5).

In this study, we report our clinical experiences with HP in 100 pediatric patients who underwent endoscopy between July 1990 and March 1993 by the Pediatric Gastroenterology Service at the Marshall University School of Medicine.

Materials and methods

The charts of all children who underwent endoscopy between July 1990 and March 1993 by the Pediatric Gastroenterology Service at the Marshall University School of Medicine were reviewed for demographic, clinical and histological data. The patients were retrospectively divided into two groups according to their antral biopsy results: HP positive (Group A) and HP negative (Group B) patients.

Pediatric endoscopes, Olympus GIF XP 10 or XP 20, were used in all patients. Three to four biopsies from the stomach (antrum) and the duodenum were taken for routine histological examination and for Giemsa stain. In each endoscopy, an antral biopsy was also taken for rapid urease test (CLO-test). CLO-test was warmed to body temperature before each endoscopy. The initial reading was done at approximately 20 minutes after endoscopy, and the final results were read at 24 hours.

Results

A total of 100 children who complained of various abdominal symptoms between July 1990 and March 1993 had an upper endoscopy as part of their medical evaluation. Ages ranged from 3 months to 20 years with a median age of 10 years. There was a total of 60 male and 40 female patients (male/female ratio 1.5). Group A had a median age of 7 years and a male/female ratio of 1.0, and Group B's median age and male/female ratio was 9 years and 1.5, respectively.

The most common presenting symptoms in both groups were abdominal pain and vomiting. Overall, there were no statistically significant differences observed in the presenting symptoms between both groups (Table 1). The rate of esophagitis was similar in both groups. The incidence of gastritis was significantly higher (up to 10 times) in patients from Group A compared to patients in Group B. Patients in Group A had a higher duodenitis rate and more severe disease compared to Group B, but those differences did not reach significance. Two patients in Group A were

TABLE 1. Presenting Symptoms

	Group A	Group B
Number of Patients	26	74
Abdominal Pain	15 (57%)	39 (52%)
Vomiting	10 (38%)	20 (27%)
Chest Pain	2 (7%)	8 (10%)
FTT	1 (4%)	7 (9%)
Weight Loss	1 (4%)	3 (4%)
Hematemesis	2 (8%)	4 (5%)

TABLE 2. Histological Results

HP	Group A POSITIVE	Group B NEGATIVE
Esophagitis	15/26 (57%)	38/74 (51%)
Gastritis	14/26 (54%)*	4/74 (5%)
Duodenitis	3/26 (11%)	4/74 (5%)
Mild	0 (0%)	4 (100%)
Moderate	1 (33%)	0 (0%)
Severe	2 (67%)	0 (0%)
Peptic Ulcer	2/26 (8%)	0/74 (0%)

*$p \leq 0.05$

diagnosed with peptic ulcer disease (Table 2). Rapid urease enzyme detection (CLO-test) identified only 19% of histologically confirmed HP patients (Table 3).

The treatment and clinical responses of the patients who were histologically diagnosed with HP are presented in (Table 4). Out of the 26 HP+ patients, six were treated with H1-blocker alone, two with antibiotic alone, six with H2-blocker and anti-HP medications (Pepto-Bismol + amoxycillin), and nine were not treated with any of these medications. The two patients diagnosed with active duodenal ulcer were treated with H2-blocker and anti-HP medication.

Three patients were lost to follow-up, but the remaining results showed that the vast majority (78%) of our patients had resolved their symptoms after up to 4.6 months follow-up, regardless of the treatment. There was also no difference in the severity of gastritis between the groups.

TABLE 3. CLO-Test Results

	Group A	Group B
CLO Positive	5/26 (19%)	2/74 (3%)
CLO Negative	21/26 (81%)	72/74 (97%)

TABLE 4. Treatment and Follow-up of Symptomatic Patients with HP

	Treatment Groups			
	H2 Alone	H2+AB+BS*	AB Alone	No Treatment
Number	6	6	2	9
Histology				
Gastritis	3/6	5/6	2/2	4/9
Esophagitis	5/6	5/6	1/2	3/9
Duodenitis	1/6	2/6**	0/2	0/9
Follow-Up				
Months (mean)	3.4	4.0	4.0	4.6
Symptoms Resolved	5/6	4/6	1/2	8/9

*H2 - H2 blocker (Zantac)
*BS - Bismuth subsalicylate
*AB - antibiotic (amoxicillin/metronidazole)
**2 patients with duodenal ulcer

Discussion

Since the discovery of HP in 1983 by Warren and Marshall (1), its distribution in Western society has been well documented. The prevalence of HP in symptomatic children has been estimated between 10 percent to 30 percent, and has an inverse correlation to socioeconomic status (15). Similar to adults, the incidence of HP in children increases with age (8,16,17,18).

Although the knowledge on HP increased significantly over the last decade, there is no data available on HP prevalence and its clinical presentation in children of West Virginia. The incidence of HP in our patient population was up to 30 percent. This figure is consistent with previous reports. As earlier observed (19), we also did not find significant differences in the clinical symptoms between patients who were HP positive or negative (Table 1). This may suggest that further laboratory evaluation is indicated in patients presenting with similar symptoms to exclude HP.

CLO-test is a rapid ureas test widely accepted as a quick method to diagnose HP during endoscopy. Several studies reported that CLO-test specificity and sensitivity is > 90% (20). The manufacturer's instruction for the use of CLO-test indicates that best results may be achieved when CLO-test is at 37°C before embedding the biopsies into the culture medium, and that final reading should be done after 24 hours. We carefully followed the manufacturer's instruction, but were able to detect only 15% of all biopsies which subsequently were confirmed histologically with HP.

The poor correlation between CLO-test and Giemsa stain may suggest that the number of HP bacterium and/or the amount of ammonia production may affect CLO-test positivity. Whether these factors are the reason for our high CLO-test false negativity rate is yet to be determined. We concluded that the clinical value of CLO-test in our practice is limited.

The current recommended treatment for HP-associated peptic ulcer disease is H2-blocker with anti-HP medications including antibiotic (amoxycillin and/or metronidazole) and bismute salts (Pepto-Bismol). Previous data in children showed that this protocol is advantageous for healing peptic ulcers compared to H2-blocker alone (21). We are not aware of any double-blind, cross-over, controlled studies evaluating the efficacy of medical treatment (placebo vs. H2-blocker with or without anti-HP medication) in children with HP-associated gastritis without ulceration.

Drumm and colleagues (22) have shown clear associations between HP and histological gastritis in children. This same group (23) has also shown that eradication of HP with medical treatment resulted in resolution of symptoms. Although this study may suggest that such treatment is indicated in children with HP-associated gastritis, their study did not contain a control group. We did not find any significant clinical advantage for either treatment for patients with HP-associated gastritis without ulceration. Since our patient population was small with a short follow-up period, we cannot draw any firm conclusions. We speculate that since true ulceration in the pediatric population is the exception rather than the rule, further controlled studies to solve this dilemma of whether to treat or not are clearly warranted.

In conclusion, this is the first report of HP in children of West Virginia. We demonstrated that HP is common in our patient population and that the diagnosis cannot be obtained on clinical ground only. Although medical treatment is recommended in symptomatic patients with HP-associated gastritis, we found symptomatic resolution irrespective of treatment regimen. We conclude that controlled studies to evaluate this dilemma are warranted.

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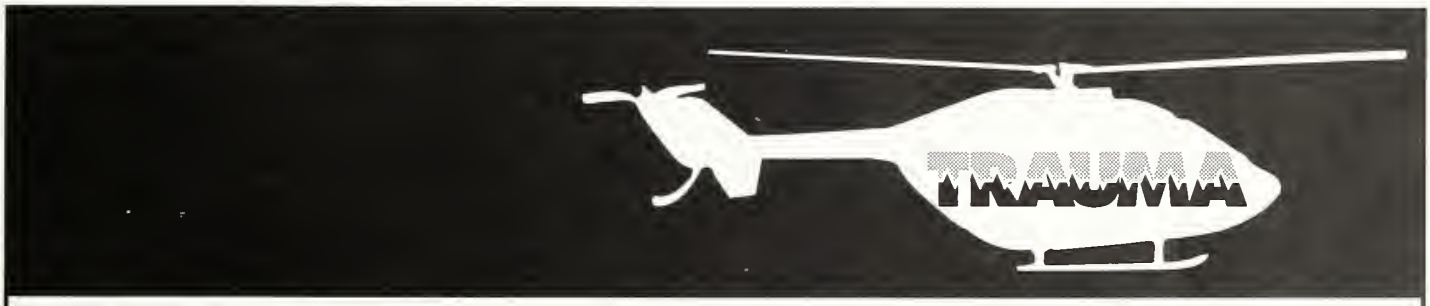

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A combined internal medicine-psychiatry clinic at a community hospital: Initial experiences

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Abstract

A new internal medicine/psychiatry outpatient clinic was recently established at Charleston Area Medical Center (CAMC). This report describes the clinical profiles of the first 52 patients and also reviews the clinic's staffing, facilities, referral sources and reimbursement. For large community hospitals, a med-psych clinic may be a useful method of providing psychiatric treatment to medically-ill outpatients.

Introduction

A variety of factors have contributed to an increased interest in combined medical-psychiatric treatment programs. From a clinical standpoint, several patient groups might benefit from such an approach (i.e. patients with concurrent medical and psychiatric illness, somatic patients, "organic" psychiatric patients, patients who refuse treatment in traditional psychiatric settings, etc...). Opportunities also exist for educational and research activities within a structured setting that provides combined medical and psychiatric treatment.

There are several reports in the literature of clinics designed to provide combined medical and psychiatric treatment. These have been labeled as "consultation liaison" clinics (1-4), "psychosomatic" clinics (5-6), "special medicine" clinics (7), "medicine/psychiatric clinics" and others (8-14).

This report describes the Multispecialty Clinic at CAMC and reviews data from the first 16 months of the clinic's operation.

The Multispecialty Clinic

The clinic opened in October 1990 with several objectives. Clinical objectives were primarily to provide outpatient psychiatric follow-up to the consultation liaison service, and to provide accessible psychiatric services to the other hospital clinics. Training objectives were to provide education to psychiatry residents, internal medicine residents, combined internal medicine/psychiatry residents, psychology interns and medical students in the area of medical psychiatry. In addition, the clinic also was established to provide a patient base for much needed research in the combined med-psych area.

The clinic was located in one of the areas at CAMC also used for other hospital clinics (i.e. medical, surgical, etc...). Only minor renovations allowed the space to be appropriate for medical psychiatric treatment as well. The clinic was conducted one morning each week and was staffed by the medical director (an internist/psychiatrist), a nurse, and a receptionist who registered patients for many clinics simultaneously. Psychiatry, internal medicine, med/psych residents, doctoral level psychology interns and medical students also participated in the clinic.

Clinical information

During the first 16 months of operation, a total of 79 new patient evaluations were scheduled, of whom 52 (67.1%) actually arrived. Compliance with scheduled follow-up appointments was 87.8% (192/230). The internal medicine clinic and inpatient psychiatric unit provided the largest number of referrals (Table 1).

Patients referred to the clinic from the consult-liaison service were the least likely to keep their initial appointment (Table 2). Demographic and clinical data regarding these first 52 patients is summarized in Tables 3-5. Females slightly outnumbered males and a wide range of ages were seen in the clinic. Cardiovascular and neurologic conditions were the most frequent medical problems; affective, anxiety and organic mental disorders were the most frequent psychiatric diagnoses.

Medical and psychiatric diagnoses among patients from specific referral sources are summarized in Tables 6-7. No statistically significant differences were present among this small number of patients. The inpatient psychiatric unit tended to refer patients with comorbid cardiac or neurologic disorders. Predictably, neurologists tended to refer those with organic mental illnesses attributable to their neurologic problems (i.e. cerebrovascular disease).

Medical/psychiatric comorbidity is summarized in (Table 8). As noted, mood and anxiety disorders were quite prevalent among those patients with cardiac and gastrointestinal disorders. Organic syndromes were seen quite often among those with neurologic illnesses.

Reimbursement information is summarized in Table 9.

Discussion

Patients with medical and psychiatric comorbidity continue to be a challenge to manage in traditional settings. Our new med-psych clinic received referrals from a variety of sources. The referral pattern likely reflected the proximity of the clinic to the medical clinic, and also familiarity with the clinic by the inpatient psychiatric service since the facility was not advertised in the local community.

Table 1. Med-Psych Clinic Referral Sources (N=52)

	N	%
Med Clinic	15	28.8
Inpatient Psychiatric Unit	11	21.1
Neurologist/Neurosurgeon	5	9.6
Cardiologist	4	7.7
Consultation/Liaison	4	7.7
Internist/GP/FP	3	5.8
Psychiatrist	3	5.8
Surgery Clinic	2	3.8
Med Rehab	2	3.9
Clinics (Other)	2	3.8
Gastroenterologist	1	1.9

Table 2. No Show Rate (Initial Appointment) According to Referral Service

Medicine Clinic	1/16	6.2%
Surgery Clinic	1/3	33%
Internist/GP/FP	0/3	0%
Cardiology	1/5	20%
Inpatient Psychiatry	7/18	38%
Consult/Liaison	7/11	63%

Table 3. Age and Sex of Med-Psych Clinic Patients (N=52)

	N	Avg. Age (yrs)
Male	23 (44%)	49.2 (range 17-83)
Female	29 (56%)	42/1 (range 23-62)

An early trend indicated a low rate (37%) of keeping appointments among patients referred from the consultation-liaison service. This may be due to the fact that these patients are ambivalent about psychiatric treatment as previously noted (2). In addition, the pattern of medical and psychiatric illnesses among referred patients may be the result of many possible factors. The most frequent diagnoses may simply reflect disease prevalence among the population, the referring physician's practice or the types of patients treated at our hospital. Referring physicians may have been better able to recognize certain psychopathology or perhaps felt least comfortable managing the types of patients referred.

A high prevalence of mood and anxiety disorders was present in patients with cardiac and gastrointestinal ailments. These associations have been previously noted (15-17), and may simply be a coincidence due to the high prevalence of all of these disorders, emotional reactions to physical illnesses, or some yet to be defined factors linking these diseases. The staff's initial experiences at this med-psych clinic have been favorable. Compliance with follow-up appointments has been good, and our reimbursement rates have been excellent. There is obviously a need for such services since patients have been referred from many areas of the medical center.

As patients continue to live longer with complex medical and psychiatric problems, community hospitals may be able to more effectively manage these patients with a med-psych clinic model.

Acknowledgements

The author expresses his appreciation to Ms. Jodi Asbury for her clerical assistance with this manuscript.

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Table 4. Medical Diagnoses of Med-Psych Clinic Patients (N=52)

	N	%
1. Cardiovascular Disease	25	48
- Coronary Disease	9	
- Hypertension	15	
- Congestive Heart Failure	4	
2. Neurologic Disease	12	
- Seizure Disorder	3	23
- Cerebrovascular Disease	4	
- Head Injury	3	
- Congenital/Other	4	
3. Gastrointestinal Disease	9	17.3
- Irritable Bowel	7	
- Inflammatory Bowel Disease	1	
- Peptic Ulcer Disease	1	
4. Endocrine Disorders	8	15.4
- Diabetes Mellitus	5	
- Thyroid Disorders	4	
5. Other Medical Illnesses	6	11.5
6. No Medical Illness	6	11.5

Table 5. Psychiatric Diagnoses of Med-Psych Clinic Patients (N=52)

	N*	%
1. Affective Disorders	28	53.8
2. Anxiety Disorders	17	32.7
3. Organic Disorders	12	23.0
4. Somatoform Disorders	7	13.5
5. Personality Disorders	12	23.0
6. Substance Abuse Disorders	9	17

* Some patients have more than one diagnosis.

Table 6. Medical Diagnoses of Med-Psych Clinic Patients From Specific Referral Sources

	Medical Clinic (N=15)	Psychiatry (N=18)	Neurology (N= 5)	Internal Medicine (N=8)
Cardiac	8	7	1	4
Endocrine	3	1	0	1
Gastrointestinal	2	1	0	2
Neurologic	1	7	3	1
Other	1	2	1	0
None	2	1	2	1

Table 7. Psychiatric Diagnoses of Med-Psych Clinic Patients From Specific Referral Sources

	Medical Clinic (N=15)	Psychiatry (N=18)	Neurology (N= 5)	Internal Medicine (N=8)
Affective Disorders	6	7	0	6
Anxiety Disorders	7	6	0	2
Organic Disorders	2	5	3	1
Personality Disorders	4	3	0	3
Somatoform Disorders	2	3	2	0
Substance Abuse	1	0	1	1

Table 8. Psychiatric Diagnoses Among Patients With Selected Medical Illnesses

	Cardiac (N=25)	Neurologic (N=12)	Endocrine (N= 8)	Gastrointestinal (N=9)
Affective Disorders	10	1	5	5
Anxiety Disorders	6	1	2	4
Substance Abuse	1	0	1	0
Organic Disorders	0	7	2	0
Somatoform Disorders	1	0	0	2
Personality Disorders	4	0	2	4

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Table 9. Payor Mix of Patients in Med-Psych Clinic (N=52) (October 1990 - March 1992)

	N	%
3rd Party Insurance	22	42.3
Medicare	11	21.5
Medicaid	12	23.0
Private Pay	7	13.5
Amount Billed	**Amount Collected**	**Rate**
$12,515.00	**$10,469.09**	**84%**

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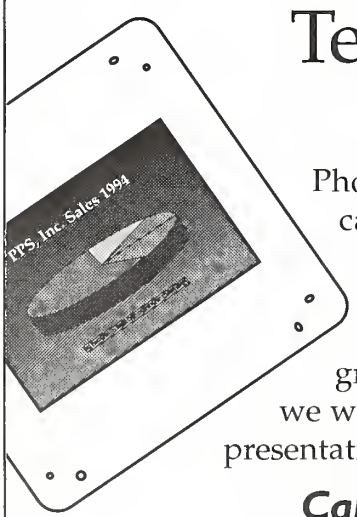

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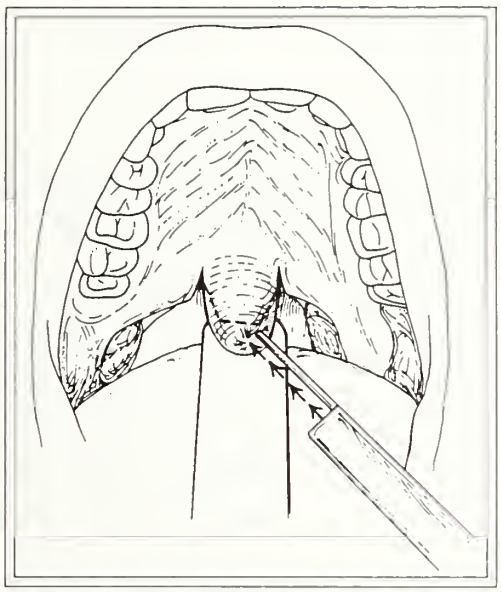

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President's Page

Change and the herding of cats

Editor's Note: The following is Dr. Burton's inaugural address which he delivered on August 20 during the WVSMA's Annual Meeting.

Ladies and gentlemen, friends, and colleagues -- I would like to thank you for the honor of serving as the president of the West Virginia State Medical Association for the coming year. It promises to be a most interesting time.

Special thanks are in order for, first of all, my partners of Radiology Inc., whose understanding and sacrifice have made this possible. I don't think I could have found a finer group of physicians to work with. Next, I'd like to thank my wife, Kathi, whose loving support is invaluable. And last, but certainly not least, I'd like to thank my parents. My father, Russ, passed away in 1989 at the age of 77. It is in his memory I dedicate this year. My mother, Fawn, will be 80 years young next month and just returned from a two-week trip to Rome and the Isle of Capri. Without their guidance, I wouldn't be standing here today.

All things change in life. I have been attending meetings of the West Virginia State Medical Association, here, at The Greenbrier, since I was a young boy in the mid-1960s. I can remember my father complaining when the rooms reached an astronomical $75 a night. It's hard to get a good bottle of wine for that these days. In part, my interest in medicine stems from those meetings.

At that time, The Greenbrier was more relaxed with a decidedly "down-home" atmosphere. I remember the starter on the Old White course recalled everyone's name and hometown, and greeted them warmly on their return. Today, The Greenbrier is different, it's larger and more sophisticated, with international renown. Yet, it retains the same impeccable standards of quality and service while the staff has that same old "down-home" friendliness.

By the same token, medicine has profoundly changed in those same thirty-odd years. Medicare, Medicaid, Health Maintenance Organizations, and Diagnostic Related Groups were all terms absent from the lexicon of the mid-60s physician. In those days, no one dared impugn a physician's character by calling him a "health care" provider.

We look upon those times of simplicity with some longing. At the same time, physicians practiced without many of medicine's modern tools we take for granted. There were not CAT Scans, MRIs, calcium channel blockers, or percutaneous cholecystectomies. We can clearly see that change is not necessarily evil for we still set the standard of medical practice for the world. We maintain our standard of excellence with that "down-home" level of compassion and caring.

Yet, as future changes loom on the horizon, I fear that outside encroachment on the traditional physician-patient relationship will damage this standard of care. As Swiss medical philosopher Ernest Truffer notes, the increasing interjection of third parties between doctor and patient "amounts to a rejection of a medical ethic which is to care for a patient according to the latter's specific medical requirements in favor of a veterinary ethic -- which consists in caring for the sick animal, not in accordance with it's specific medical needs, but according to the requirements of its master and owner, the person responsible for meeting any costs incurred. I'll tell you now -- I do not intend to be a "health care provider," I am a physician. I do not intend to practice "veterinary medicine" -- my patients deserve better.

A crisis exists in health care today. I'm not talking about the crisis of the uninsured, of runaway costs or of over utilization. What I'm talking about is a crisis of spirit, amongst us, the physicians. I hardly know a doctor over 50 who isn't glad he's nearer retirement than not. The physicians of my generation are profoundly discouraged. The topic of discussion typically evolves about their wish to be in some other profession. It's sad to think that bureaucracy, the threat of malpractice suits, the uncertainty in our practice, and the disrespect of our patients and the press has reduced us to this. My father always preached the value of an education -- something he said that could never be taken away. He'd be sad to learn they're trying to do just that.

I fear most of all for the welfare of our patients. The one group most confused and misled by the rhetoric, yet most affected by coming changes. They will be inundated by a vast array of plans and options; none of which may suit their needs.

Through it all, there will be a marked decrease in the level and sophistication of services. Despite what is said, rationing will occur; and choice, for both the patient and the physician, will be a thing of the past.

Why, I ask you, is this considered progress?

To my knowledge, we, the physicians, are the only ones with the training and education to practice what truly is the "Art of Medicine." No one, not administrators, insurance executives, managed care coordinators, and least of all, government bureaucrats, can make that claim. Somewhere along the line, someone, or maybe all of us, should say "ENOUGH."

I was once told that getting doctors to agree is like trying to herd cats. This year, I intend to do just that. There is no one in this state that will be a stronger advocate for your rights, no matter what specialty you may practice, than I. If you'll support me, I hope that next year at this time, West Virginia, a state I love, will be a little better place for you to practice the art and science of medicine.

Dennis M. Burton, M.D.

Editorial

Contemplating the complexities

Into an increasingly complex society, there has come stalking the medical care delivery giant, sending the entire population scurrying in all directions. The politicians, the lawyers, the lawyer-politicians -- are all at the center of these controversial discussions as to the best way to subdue this bumbling giant and make him subservient to their plans for society and themselves. As a result, we've been hearing more and more about the uninsured, the underinsured, the indigent, the wealthy, Medicare, Social Security, entitlements, PROs, balance billing, managed care, pre-authorizations, cost controls, rural health, physician shortages and overages, electronic billing, universal coverage and on and on.

One is forced to wonder how much understanding the average person -- indeed the average physician -- has of the whole matter. Our political representatives have been hatching ideas for monolithic health care systems for the past many months. And then someone thought to ask the General Accounting Office for some cost estimates. Suddenly some plans were quietly abandoned by their authors. For at that point it became obvious that this kind of a free and accessible medical care system is truly the way to bankruptcy.

One of the most disturbing aspects of the whole controversy is the anxiety besetting the average office holder concerning his re-election in the coming months. A reasonable worry for the average citizen is that his or her political representatives might be panicked into trying to satisfy shortsighted constituents by passing some disastrously liberal legislation in an effort to insure re-election.

On the brighter side, our medical organizations have done a tremendous job of educating some senators and representatives as to the concern the medical profession has for its patients, as evidenced by the proposed Patient Protection Act, and tax-exempt Medical Savings Accounts.

It remains to be seen whether or not the federal government will manage to bring down the world's best system which adequately cares for at least 85 percent of its population, in a vain effort to improve the condition of the remaining 15 percent. No one denies the obligation of society to care for those least able to care for themselves. It is equally clear that not to learn from the failures of systems of other nations is certainly inexcusable.

Joe N. Jarrett, M.D.
Associate Editor

The legal responsibility of physicians supervising physician assistants is significant

The role of physician assistants within West Virginia has consistently been expanded since the initial statutory authority was given enabling physician assistants to function in 1971. The standards for licensure of physician assistants have continually been upgraded, however, the legal responsibility of the physician supervising the physician assistant has remained constant through the years.

The West Virginia Code S30-3-16(h) reads "The legal responsibility for any physician assistant remains with the supervising physician at all times, including occasions when the assistant under his or her direction and supervision, aids in the care and treatment of a patient in a health care facility." Under the law and regulations, there must be a person approved by the West Virginia Board of Medicine as a supervising physician for a physician assistant before the physician assistant may be licensed to practice as a physician assistant within the state. The physician assistant is limited to the performance of those services for which he or she is trained and performs only under the supervision and control of a person permanently licensed in West Virginia. A physician assistant may not perform any services which his or her supervising physician is not qualified to perform.

There must be an established relationship between physician and physician assistant before the physician assistant may function in West Virginia. The physician assistant acts as an agent of the supervising physician at all times. In fact, it is the physician applying to the West Virginia Board of Medicine to supervise a physician assistant (not the physician assistant) who is required to provide a job description to the Board which sets forth the range of services to be provided by the physician assistant (West Virginia Code S30-30-16(g).

No physician assistant is able to function legally in this state without a license from the West Virginia Board of Medicine, without a Board approved supervising physician and without a job description which is Board approved. Physician assistants are different from nurse practitioners in training, national board certification, and licensure. There are similarities between these two professions; but the legal requirements for the two professions are different.

The legal requirements for and relationship between physicians and physician assistants is an area not often understood fully by physicians. The West Virginia Board of Medicine has recently again mailed all physicians in the state the laws and regulations governing the practice of physician assistants.

Since the West Virginia Board of Medicine has jurisdiction over physicians and physician assistants, the members of the Board want practitioners to know what to do to comply with these requirements and function properly. For example, no supervising physician may employ at any one time more than two physician assistants. When functioning as a physician assistant, a physician assistant must wear a name tag which identifies himself or herself as a physician assistant.

We encourage physicians who have questions to contact the Board offices at (304) 558-2921 for assistance.

Michael Grome, P.A. –C
Chair, Physician Assistant Committee
West Virginia Board of Medicine

Deborah Lewis Rodecker, J.D.
Counsel
West Virginia Board of Medicine

Some questions for Senator Rockefeller

The editorial by Stephen Ward in the July issue deserves some further consideration. Hypocrisy in our elected officials is a major detestation of the American people, and each episode of hypocrisy needs to be pointed out.

I believe that it would be wise for the *West Virginia Medical Journal* to write to Senator Rockefeller to request a copy of his medical record for evaluation. Some of the more interesting aspects might be as follows:

1. Did Senator Rockefeller have a back problem while he was living in West Virginia?
2. Did he have the diagnosis made by a generalist or by a specialist?
3. Did he seek treatment in this state or did he go elsewhere for any necessary surgery.

And that's just for starters.

4. We should also request information as to whether he and his family would be enrolled in a West Virginia plan for their future medical care?
5. If he is enrolled in a federal plan in Washington, will he enjoy any privileges not accorded to the plans in West Virginia.
6. Will the doctors in his plan be recompensed at a higher rate than West Virginia physicians?

The list of questions could go longer, but I think that those will suffice to point out some inconsistencies in the medical programs which he backs.

James H. Wiley, M.D.
Morgantown

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8th FP Weekend/Sports Medicine Conference set

The West Virginia Chapter of the American Academy of Family Physicians and the Family Medicine Foundation of West Virginia will present their 8th Annual Family Practice Weekend and Sports Medicine Conference at the Radisson Hotel in Huntington from November 11-13.

Sponsors for this year's event include the Family Medicine Foundation of West Virginia, the Marshall University Department of Family and Community Health, and Jose Ricard, M.D., of the Marshall University Sports Science and Wellness Institute. The conference has been reviewed and is acceptable for 18.0 prescribed hours by the AAFP, as well as AOA credit toward Category 2A for 18.0 hours.

A preconference workshop on managed care has been scheduled for Thursday, November 10 from noon to 6:30 p.m., and then the meeting will officially kickoff on Friday, with registration at 7 a.m. The first scientific session will begin at 8:20 a.m. and is entitled *"The Physical Allergies: Implications for Exercising Patients"* by William Briner, M.D., of Parkside Sports Medicine Center in Park Ridge, Ill. The other speakers that morning will be Earl Foster, M.D., of Scott Orthopedic Center in Huntington on *"Common Hand Injuries in Sports;"* Kenneth Wolfe, M.D., of Tri-State Otolaryngology in Huntington on *"The Dangers of Smokeless Tobacco Use in Sports;"* Manuel Molina, M.D., of CAMC on *"Common Knee Injuries in Recreational Sports;"* and Ross Patton, M.D., of Marshall University on *"Problems in Altitude."*

Friday afternoon, the sessions will continue at 1 p.m. with a lecture by Jim Donnan, head coach of the Marshall University Thundering Herd, about *"Sports Medicine: Benefits to Our Athletes."* After Donnan's presentation, Joseph Touma, M.D., of the Huntington Ear Clinic, Inc., and Phillip Stevens, M.D., of Tri-State Otolaryngology, will discuss *"Ear Injuries in Water Sports."* Three more topics will be featured during this afternoon including *"Managing Infections in the Outpatient Athlete"* by Richard Quintiliani, M.D., of Hartford Hospital in Hartford, Conn.; *"Treatment of Skin and Soft Tissue Infections"* by Ellis Caplan, M.D., of the University of Maryland; and *"Infectious Complications in Trauma Patients"* by John Kizer, M.D., of WVU.

Briner

Breyer

Jacobs

The CME events will continue on Saturday morning at 8:15 a.m. with *"Stalling Complications of Diabetes"* by Julia Breyer, M.D., of Vanderbilt University. Following Dr. Breyer's lecture, Robert M. Guthrie, M.D., will discuss *"Challenge in Clinical Practice: Changing the Natural History of Coronary Artery Disease"* by Robert Guthrie, M.D., of Ohio State University. The next presentation will be *"Cardiologists' Modern Treatment of Angina"* by Dennis DeSilvey, M.D., of the University of Virginia. The final morning lecture is entitled *"Hypertension and Renal Disease"* by Jay Wish, M.D., of the Cleveland Clinic.

After lunch, the scientific sessions will reconvene at 1 p.m. with *"Irritable Bowel Syndrome"* by Lawrence Schiller, M.D., of Baylor University Medical Center. Additional subjects to be highlighted during the afternoon will be *"Treatment of Obsessive Compulsive Behavior"* by Peter Stokes, M.D., of New York Hospital; *"Choosing the Appropriate Antibiotic in the 90s: A Case Study Approach"* by Norman Jacobs Jr., M.D., of Decatur, Ga.; *"Lower Respiratory Tract Infections"* by Richard Brown, M.D., of Baystate Medical Center in Springfield, Mass.; and *"Sinusitis in the Adult and Pediatric Population"* by Nelson Gantz, M.D., of the Polyclinic Medical Center in Harrisburg, Pa.

Sunday's programs will also start at 8:15 a.m., and the first talk scheduled is *"Management of Hypertension in a Type II Diabetic"* by John Levine, M.D., of Nashville, Tenn. Also on Sunday morning's agenda will be *"Treatment of Community-Acquired Pneumonias"* by Gary Stein, Pharm.D., of Michigan State University; *"Allergic Rhinitis"* by Helen Krause, M.D., of Pittsburgh; and the concluding lecture for the conference, *"Gastroesophageal Reflux Disease: Update on Pathogenesis and Treatment"* by Timothy Bulkley, M.D., also of Pittsburgh.

In addition to the preconference workshop and the scientific sessions, this year's meeting will again feature exhibits, and a number of business and social events, including a fund raising party at Rocco's Four Seasons with the Full Tilt Band. For more information, phone 776-1178.

Mark your calendars now for Mid-Winter!

This year's WVSMA's Mid-Winter Clinical Conference is scheduled for January 19-22 at the Radisson Hotel in Huntington.

Please turn to page 380 for more details about the conference, or you may phone Nancie Divvens at (304) 925-0342 for additional information.

Dr. Esposito honored by Cabell County Medical Society

The Cabell County Medical Society dedicated its June meeting to honor one of its members, Dr. Albert C. Esposito, in recognition of the 20th anniversary of his success in bringing the medical school to Marshall University.

It was on June 5, 1974, that Dr. Esposito was notified by Senator Robert Byrd and Richard Roudebush, secretary of the Veterans Administration, that one of the new V.A. assisted medical schools was being awarded to Marshall University. According to Roudebush, the new medical school was awarded to Marshall University because of Dr. Esposito's origination of the concept of a law to create V.A. assisted medical schools and his tremendous efforts to enact this federal legislation. This law was signed by former President Nixon, whom Dr. Esposito had met with personally back in 1971 to discuss his concept of a Veterans Administration Medical School Assistance Program.

The Cabell County Medical Society also honored Dr. Esposito in 1978 when they created the Dr. Albert C. Esposito Lectureship. This lectureship was turned over to the Marshall Foundation and included funds for the portrait of Dr. Esposito and bronze plaque which are now displayed at the Marshall University School of Medicine.

Tulane University, ACPE create new master's degree

Tulane University has announced the development of a new master of medical management degree designed to train physicians for administrative leadership roles.

This new degree evolved from a partnership established with the American College of Physician Executives. It offers physicians the opportunity to develop medical management skills without a significant career interruption.

The degree will build on the certificate in medical management currently offered by ACPE. Physicians who hold a certificate in medical management may earn a master's degree by completing three one-week sessions on the Tulane campus in New Orleans with intervening at-home study.

For more information on the master's degree in medical management at Tulane or the certificate in medical management, call ACPE at 800-562-8088.

Rush-Presbyterian schedules liver disease symposium

"Approaching Liver Disease Management with Evolving Therapeutic Techniques" will be the topic of the Fifth Annual Rush Symposium on Hepatic and Biliary Disease and Liver Transplantation at Rush-Presbyterian-St. Luke's Medical Center in Chicago on November 11.

This conference is designed to give attention to evolving techniques for successfully treating cholestatic liver disease, hemochromatosis, and autoimmune liver disease. A special registration rate is available for fellows and postdoctoral students.

To register, call the Transplant Program Physician Relations Coordinator at (312) 942-6242.

Reno site of NAHQ annual conference

The National Association for Healthcare Quality's (NAHQ) 19th Annual Educational Conference will take place October 2-5 in Reno, Nev.

This meeting is designed to help prepare health care leaders for the future by providing them with the essential tools and techniques of quality improvement to use in any health care setting. It will feature five concurrent tracks, four general sessions, paper and poster presentations, special interest networking sessions, and over 65 exhibitors. Preconference workshops will also be offered prior to the conference on Sunday, October 2.

For details, contact the NAHQ at (708) 966-9392, or fax (708) 966-9418.

ACC, National Health Council to sponsor Washington meetings

The American College of Cardiology is sponsoring a conference entitled *"New Techniques and Concepts in Cardiology,"* which will be presented October 20-22 in Washington, D.C.

This meeting is approved for 16 CME credits in the AMA's Category 1. For more information, contact the ACC at (800) 257-4739 or (301) 897-2695 for outside the U.S. and Canada.

Another conference which will be taking place this fall in Washington, D.C., is the National Health Council's 41st Annual National Health Forum on *"The Three Rs of Environmental Health: Risk, Reality and Responsibility."* This forum is scheduled for September 29 and will feature experts from a cross-section of the health care and environmental fields.

For more details, phone Bob Goldberg at (202) 785-3910.

University of Maryland to present endocrinology update

The Division of Endocrinology and Metabolism and the University of Maryland School of Medicine are sponsoring *"Endocrinology Update for the Practicing Physician 1994"* on October 7 and 8 in Baltimore.

This CME event is designated for 10 credit hours in Category 1 for the Physician's Recognition Award of the AMA.

Contact Dorothy Taylor at (410) 328-2515 for more details.

Annual Clinical update in pulmonary medicine announced

The Eleventh Annual Clinical Update in Pulmonary Medicine has been announced by Course Director Mervyn Feierstein, M.D., of the Deborah Heart and Lung Center in Browns Mills, N.J. This one-day course will take place at Bally's Park Place Casino Hotel and Tower in Atlantic City, N.J. on Saturday, December 10.

Sponsored by the Department of Pulmonary Medicine at the Deborah Heart and Lung Center, this CME program is designed to provide physicians with a balance of established standards of care and new methods and therapies in pulmonary diseases, as well as a state-of-the-art review of pulmonary disorders commonly seen in a clinical setting. Important topics to be addressed include: asthma management, COPD, diffuse lung disease, lung cancer, tuberculosis and non-tuberculous, mycobacterial infections, pulmonary fungal infections, pulmonary complications of HIV infection, and ethical dilemmas in the ICU.

For further information, contact the Center for Bio-Medical Communication, Inc., 80 West Madison Avenue, Dumont, NJ 07628, (201) 385-8080.

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Radisson Hotel - Huntington

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Special topics to be featured include:

Joint Sessions

"Use of Growth Hormone in the Adult and Aging Population"
"New Concepts in Gastro-esophageal Reflux Disease and Ulcer Disease"
"Lessons Learned from Vaccine Use During the Past 40 Years"
"Peripatetic Plastic Surgeons: Benefactors of Mankind or Innocents Abroad?"

Physician/Public Session

"Health System Reform/Managed Care"

Sexually Transmitted Diseases

"Human Papilloma Virus Infections"
"Treatment of Chlamydia, Gonorrhea and Other Sexually Transmitted Diseases"

Controversies in Medicine

"Screening Mammography"
"Coronary Artery Disease: Medical vs. Surgical Management"

Potpourri of Topics

"Pain Control, Assessment and Treatment: Post-Operative and Terminal"

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Fayette County
Thursdays
December 1st, 8th & 15th

- ❑ **Clarksburg Area** September 1994
- ❑ **Beckley Area** October 1994
- ❑ **Charleston Area** November 1994
- ❑ **Fayette County** December 1994

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Continuing Medical Education

Listed on this page are some of the upcoming CME programs which will be held in the state. Unless otherwise noted, the events are presented at the location under which they appear.

If you would like to have the CME programs offered by your institution or association for physicians printed in the *Journal* or obtain more details about the meetings listed, please contact Nancy Hill, managing editor, at 925-0342.

Marshall University - Huntington

September 30
"4th Annual Cancer Conference," St. Mary's Hospital

October 1
"8th Annual MU School of Medicine Alumni Weekend," Radisson Hotel

October 8
"Behavioral Management of the Demented Nursing Home Patient," Glade Springs

Robert C. Byrd Health Sciences Center of WVU - Charleston

October 6
(Teleconference) "Gestational Diabetes in Pregnancy," David G. Chaffin, M.D.

October 20
(Teleconference) "Emergency Department Approach to the Febrile Pediatric Patient," Dept. of Emergency Medicine, CAMC and Women and Children's Hospital

Robert C. Byrd Health Sciences Center of WVU - Morgantown

September 23-24
"The 15th Annual Clinical Ophthalmology Conference" (sponsored by WVU Dept. of Ophthalmology and the WV Academy of Ophthalmology), Lakeview Resort and Conference Center, Morgantown

October 7-8
"Pediatric Oktoberfest '94'" (sponsored by the WVU Dept. of Pediatrics), Robert C. Byrd HSC of WVU, Morgantown

October 21-22
"Surgery Update" (sponsored by the WVU Dept. of Surgery and WV Chapter of the American College of Surgeons), Robert C. Byrd HSC of WVU, Morgantown

Outreach Programs

Key to Sponsors

★ *Robert C. Byrd Health Sciences Center of WVU, Morgantown*

☐ *CAMC/Robert C. Byrd Health Sciences Center of WVU, Charleston*

Fairmont ★ Fairmont General Hospital, Oct. 4, 7:30 p.m. "Pediatric Cardiology Update," Stanley Einzig, M.D

Gassaway ☐ Braxton County Memorial Hospital, Sept. 28, 6:30 p.m., "Trauma Resuscitation: Optimizing in the Golden Hour," Trauma Services

Lewisburg ☐ WV School of Osteopathic Medicine, Sept. 27, "Diabetic Eye Disease," Michael P. Varley, M.D.

Logan ☐ Logan General Hospital, Sept. 16, 11:45 a.m., "Trauma Resuscitation: Optimizing in the Golden Hour," Trauma Services

Man ☐ Man Appalachian Regional Hospital, Sept. 21, 6:30 p.m., "Disease of the Larynx," James T. Spencer, M.D.

Martinsburg ★ VA Medical Center, Oct. 6, 3 p.m., "Acute Respiratory Failure," Harakh Dedhia, M.D.

New Martinsville ★ Wetzel County Hospital, Oct. 13, noon, "Exercise Testing for the Primary Care Physician," Anthony Morise, M.D.

Oak Hill ☐ Plateau Medical Center, Sept. 27, 6:30 p.m., "The Pitfalls in the Initial Evaluation of the Trauma Patient," James W. Kessel, M.D.

Parkersburg ☐ Camden Clark Hospital, Sept. 29, noon, "Diabetic Eye Disease," R. Mark Hatfield, M.D.

Point Pleasant ☐ Pleasant Valley Hospital, Sept. 22, noon, "Medical Oncology Emergencies," Steven Jubelirer, M.D.

Richwood ☐ Richwood Area Medical Center, Sept. 20, 5:15 p.m., "Management of Low Back Pain," Kenneth Wright, M.D.

Spencer ☐ Roane General Hospital, Sept. 20, 12:15 p.m., "Trauma Resuscitation: Optimizing in the Golden Hour," Trauma Services

White Sulphur Springs ★ The Greenbrier Clinic, Sept. 26, 4 p.m., "Breast Cancer," Edward Crowell, M.D.
★ The Greenbrier Clinic, Oct. 24, 4 p.m., "Office Practice of Sports Medicine," William Post, M.D.

** To be announced*

Searching for the Cure.

Cancer sounds like such a grown-up disease, but each year, more than 6,000 American children will be stricken. The doctors and scientists at St. Jude Children's Research Hospital are working to wipe childhood cancer from the face of the earth. To learn more about this life-saving work, please call **1-800-877-5833.**

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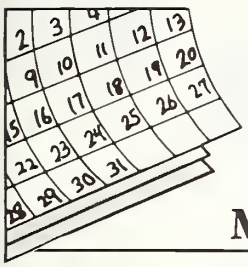


Medical Meetings

September

26-27–The Transition from Clinician to Manager: Administration in Human Service Organizations (sponsored by The Menninger Clinic), Topeka, Kan.

26-28–The 18th National Conference on Correctional Health Care (sponsored by the National Commission on Correctional Health Care), San Diego

28-Oct. 1–American Association for the Surgery of Trauma, San Diego

29-The Three Rs of Environmental Health: Risk, Reality and Responsibility, the National Health Council's 41st Annual National Health Forum, Washington, D.C.

29-30–Healthcare Quality Management: Review and Study Session (sponsored by the National Association for Healthcare Quality), Reno, Nev.

29-Oct. 1–Second Annual Conference of Rural Health Clinics (sponsored by The National Rural Health Association), Arlington, Va.

October

1–Dementia Update (sponsored by Ohio State University), Columbus

6-9–38th Annual Meeting of the American Society of Internal Medicine, Dallas

7-8–Endocrinology Update for the Practicing Physician 1994 (sponsored by the University of Maryland School of Medicine), Baltimore

7-8–Cardiology Update 1994 (sponsored by Ohio State University), Columbus

16-19–16th Annual Meeting of the Society for Medical Decision Making, Cleveland

21-22–Communication Approaches for Tracheostomized and Ventilator Dependent Patients (sponsored by Voicing!, Inc.) New York City

24-28–Prevention in Practice: Workplace Health in the 21st Century (sponsored by the American College of Occupational and Environmental Health), Denver

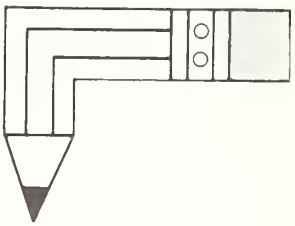
27-30–The First International Conference on Prevention (sponsored by the World Health Organization, The Council of Geriatric Cardiology, The Center for the Study of Aging, The Lawrence Frankel Foundation, the Robert C. Byrd Health Sciences Center of WVU, the three medical colleges of West Virginia, and Senator Jay Rockefeller), Charleston, W.Va.

28-29–Clinical Innovations in Ob/Gyn Ultrasound (sponsored by the American Institute of Ultrasound in Medicine), New York City

For More Information . . .

Contact the Journal at (304) 925-034

Poetry Corner



Caring For Generations

Then
I was an aide in sixty-three,
In a long-term care facility.

Patients' needs were cared for on the spot,
Whether they wanted it done or not!

The patient's rights was a term yet unheard,
The doctor's wishes were our final word.

I didn't question, did what I was told,
We nagged, we bossed, we even used to scold!

They took their pills, with or without a fuss,
Then all were told, we know best, trust us.

The patients all did just as they were told,
But this was in "Nursing Home days of old."

Now
Now I'm a nurse and again you see,
I work in a long-term care facility.

But everythings is oh so different now,
The patient has rights and they're stressed, and how.

We don't do a treatment or dare give them pills,
Until we take time to explain all their ills.

Our residents live here, and this is their place,
The staff watches over them, but gives them space.

Residents can have company any old time,
Hours aren't restricted, no "Keep Out" sign.

With their consent, we care for them, body and mind,
Caring for them has its own rewards, we find.

Then and now, it's our main declaration,
We still care, for all our generations.

Twyla E. Vincent, R.N., B.S.N.

Please address your submissions for Poetry Corner to Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

Department of Health & Human Resources
Bureau of Public Health News

This page of material is submitted and paid for by the Bureau of Public Health.

Bureau examines role of public health in health care reform

The Bureau of Public Health is joining agencies around the nation in undertaking a number of activities to ensure that public health is an important component of any state or federal health care reform package.

The mission of public health is to prevent illness and injury. In the U.S., more than 500,000 people work at the federal, state, county and municipal levels to carry out this mission and the following public health core functions:

* Preventing epidemics
* Protecting the environment, workplaces, housing, food and water
* Promoting healthy behaviors
* Monitoring the health status of the population
* Mobilizing community action for health
* Responding to disasters
* Assuring the quality, accessibility, and accountability of medical care
* Reaching out to link high risk, disadvantaged to needed services
* Providing medical care when needed
* Securing a skilled public health workforce
* Researching for new insights and innovative solutions
* Leading the development of sound health policy and planning

Currently, less than 1% of the national budget for health care expenditures is devoted to functions of public health, while the remainder is targeted for medical treatments. Yet, nearly 70% of early deaths in the U.S. could be prevented by population-wide public health approaches, compared to about 10% that could be prevented by medical treatment, and 20% that are genetic and could not prevented.

To fund fully effective public health services, only $100 per person per year would be needed, compared to nearly $4,000 per person per year that is currently being spent in sick care. Investing in public health can keep the nation's citizens well and safe, and can save billions of dollars in sick care costs. For example, every dollar invested in:

* chicken pox vaccinations saves $5.40 in sick care and hours of lost work.
* stop smoking programs for pregnant women saves $4.40 in sick baby care.
* AIDS prevention saves upward of $15 in sick care.

In addition, a 3% reduction in:

* the 265,000 coronary bypass operations performed each year would save $240 million a year in sick care if there were more public programs on exercise and nutrition
* the 1.1 million new cases of lung cancer diagnosed each year would save $780 million in sick care - - realized with the aid of public health smoking prevention and cessation campaigns
* the 600,000 strokes suffered each year would save $396 million a year - - realized with the aid of public health high blood pressure control programs
* the 140,000 disabilities caused each year by farm accidents would save $108 million a year - - realized with the aid of public health safety programs

These measures alone could save as much as one and one half billion dollars every year. Annual sick care costs from preventable illnesses include:

* $100 billion - injuries
* $70 billion - cancer
* $135 billion - cardiovascular diseases
* $1.6 billion - fetal alcohol syndrome birth defects
* $4.3 billion - lead toxicity in children under six

Heart disease remains the number one cause of death in West Virginia, taking the lives of nearly 7,000 state residents last year. That accounted for approximately 35% of all state deaths in 1993, with cancer accounting for another 23%, and cerebrovascular diseases accounting for 6%. Throughout the 20th Century, the leading causes of death in the state and the nation have shifted dramatically from infectious diseases to chronic conditions. More sanitary living conditions, the discovery and administration of immunizations and other numerous public health activities have helped to reduce and even eliminate many of those infectious diseases that threatened the population in years past. Yet, when federal funding for tuberculosis control was cut in the 1980s, it took only a few years for TB case rates to begin climbing again.

Whether or not health care reform policies are passed this year in the Legislature or in Congress, several organizations are moving ahead to confront public health concerns in West Virginia. Earlier this year, the Bureau of Public Health joined the West Virginia Public Health Association and the Association of Local Health Departments in publishing a white paper entitled, "*Public Health in a Reformed Health Care System.*" In addition, Bureau Commissioner William T. Wallace Jr., M.D., M.P.H., has appointed a 20-member panel to address public health concerns and to offer progressive solutions to them.

For more information, contact the Bureau of Public Health at (304) 558-2971.

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ROBERT C. BYRD HEALTH SCIENCES CENTER OF WEST VIRGINIA UNIVERSITY

Compiled from material furnished by the Robert C. Byrd Health Sciences Center of West Virginia University, Communications Division, Morgantown

Former University Hospital is renamed

The former University Hospital has been renamed the Hazel Ruby McQuain Pavilion in honor of her support of WVU.

"The support Hazel Ruby McQuain has given this institution has helped establish a comprehensive, modern facility for medical care and training," said University President Neil Bucklew. "The naming of this pavilion in her honor is an expression of the gratitude we share for Mrs. McQuain, who has done so much to advance health care for residents of West Virginia and the surrounding region."

McQuain's contributions to WVU exceed $13 million. The centerpiece of the WVU's medical care is Ruby Memorial Hospital, which is named for McQuain's late husband, John Wesley Ruby. A gift of $8 million from McQuain in 1984 helped make the new hospital possible. It was the largest single donation in WVU history, and it ranks among the most significant acts of individual philanthropy in support of higher education and health care in the region.

The Hazel Ruby McQuain Pavilion, referred to as Health Sciences South since the opening of Ruby Memorial Hospital, houses clinics for family medicine and dentistry, the Center for Rural Emergency Medicine and the School of Nursing, and other facilities.

WVU to affiliate with The Health Plan

Residents of north central West Virginia will soon have the option of joining the state's largest and oldest health maintenance organization.

The affiliation of the Robert C. Byrd Health Sciences Center of WVU with The Health Plan of the Upper Ohio Valley will bring together two large non-profit health care organizations.

"We are certain the alliance of WVU and The Health Plan will represent a very strong, attractive choice for people who are ready to opt for an HMO," said Philip D. Wright, president of The Health Plan.

According to Dr. Robert D'Alessandri, vice president for health sciences and dean of medicine at WVU, HMOs are very effective at containing costs.

"We'll put emphasis on prevention and wellness, as well as education of members," Dr. D'Alessandri said. "We intend to keep as much health care as possible in the local communities of The Health Plan members. Our main goal is to continue to provide quality services while containing costs."

Vale cited in *New York Times* article

Vale

Dr. Janie Vale, assistant professor of occupational medicine and orthopedics, has been cited in the *New York Times* for pioneering an upper extremities cumulative trauma disorder screening and intervention protocol.

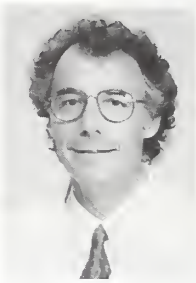
At a Tyson Foods poultry processing plant, worker's compensation fees were reduced to $1,000 from $106,000 in two years through a comprehensive ergonomics and medical management program designed by Dr. Vale.

Granke becomes registered cardio tech

Dr. Kenneth Granke, assistant professor of surgery, recently became a registered cardiovascular technologist and was asked to sit on the Board of Exam Writers of Cardiovascular Credentialing International.

Dr. Granke also recently attended the joint meeting of the Northeastern Chapter of the International Society of Cardiovascular Surgery and Vascular Surgery in Seattle.

Chisholm co-chairs surgery symposium



Chisholm

Dr. Lionel Chisholm, professor of ophthalmology, recently co-chaired the Vitrectomy Surgery Symposium at the International Congress of Ophthalmology in Toronto.

This symposium addressed the 25 years of progress in this surgical field.

Saw participates in physicists' meeting

Cheng B. Saw, Ph.D., associate professor of radiation oncology, recently attended the American Association of Physicists in Medicine annual meeting in Anaheim, Calif.

Dr. Saw chaired a session on brachytherapy at the meeting and also presented three papers co-authored by Dr. Leroy Korb, associate professor and section chief, and Todd Pawlicki, MS, radiation oncology.

Orthopedic faculty present research

Several research projects of faculty in the Department of Orthopedics were presented at the World Congress of Biomechanics in Amsterdam in July.

Associate professor Dr. Jaiyoung Ryu, and Assistant Professor Jungsoo Han, Ph.D., had 7 projects accepted. In addition, Assistant Professor Corrie Mancinelli, P.T., Ph.D., and Dr. J. David Blaha, professor and chair, also had a project accepted as an oral presentation.

Macsai elected to EABB executive committee

Dr. Marian Macsai, associate professor of ophthalmology, has been recently elected to the Executive Committee of the Eye Bank Association of America.

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

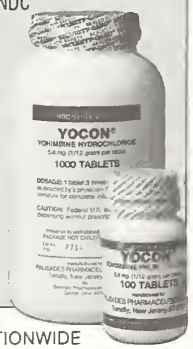
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85



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Marshall University School of Medicine

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington

PBS special to highlight Internet, RuralNet

Computer outreach activities of the School of Medicine will be featured in an upcoming Public Broadcasting System documentary about the Internet.

Scheduled to air in December, the program will show viewers how to access the Internet and highlight several innovative ways it is being used, according to Brandenburg Productions producer Phillip Byrd.

"We want to show how the Internet really affects people's lives, that it's not just CB radio via e-mail," he said.

After reading about Marshall's Science by E-mail program in a compilation of "500 Neat Things on the Internet," Byrd and his colleagues came to Marshall in July to film a segment about that program. Once here, they became so intrigued by Marshall's computer network linking rural medical centers that they quickly revised their plans so they could include RuralNet as well.

"We found people at clinics in rural West Virginia -- not what one would think of as a major medical center -- working with the most current, up-to-date medical information," Byrd said.

Created to support Marshall students who were spending nine months at rural sites through the Rural Physician Associate Program, RuralNet soon expanded to serve the hundreds of health professions students working at rural sites throughout West Virginia through the Kellogg Community Partnership Program and the Rural Health Initiative. RuralNet allows students to communicate with one another and their professors as well as to access educational and worldwide clinical resources.

In addition to helping students and providers gather information from anywhere in the world, RuralNet in turn offers Internet users worldwide to tap into the school's collection of rural health resources.

Harts High School officials opened the school in late July so that Carol O'Connell and her students could re-enact their Science by E-mail activities. With the cameras rolling, students used electronic mail to talk with a mentor and used a popular Internet tool called a gopher to connect to the National Aeronautics and Space Administration.

Dr. Susan DeMesquita of Marshall, who with Professor Jan Fox developed the Science by E-mail project, said the public school students became quite adept at traveling the information superhighway.

"Some of the students contacted Tasmania and began conversing electronically with pen pals there," she said. "They certainly proved that although our geography is isolated, our students don't have to be. They just needed more opportunity. They had 30 students using one computer for one 45-minute period a day; they actually came to physical blows on the playground over who got to use it first. If they had had 10 or 15 computers, they would have had pen pals all over the world."

Competition may not be so fierce in the future, thanks to the public television visit.

"We were afraid that the computer at Harts would not be one we could shoot for technical reasons, so we asked Compaq, which was underwriting the program, to provide a computer we could take with us," recalled producer Byrd. "The person we were working with agreed, but then someone at Compaq said 'No . . . one isn't enough,' and so the company sent the school three new computers."

First Project SEED students complete

Two Tri-State high school students recently completed their participation in the first Project SEED Program at the School of Medicine. Project SEED is the American Chemical Society's social action program providing high school students with an opportunity to work as part of a team doing hands-on research. The research apprenticeship experience provided by Project SEED contributes to career development and educational growth of the students.

Dr. William B. Rhoten, chair of the Department of Anatomy Cell and Neurobiology, received national competitive funding from the American Chemical Society for the program. Aleisha Blake of Huntington East High School worked with M. Aslam Chaudhry and Dr. Rhoten on the research topic "Chemistry at the Cellular Level." Nadine Bridges of Huntington High School worked with Dr. Igor N. Sergeev, Michelle Carney and Dr. Rhoten on "Calcium and the Living Cell."

Mufson, colleagues awarded Louis Weinstein Award

Dr. Maurice A. Mufson of Marshall and research colleagues in Houston have received the Louis Weinstein Award of the journal Clinical Infectious Diseases. The award honors the best clinical article published in the journal between July 1993 and July 1994.

The article for which they were honored is entitled "Antibody to capsular polysaccharides of the *Streptococcus pneumoniae:* prevalence, persistence and response to revaccination." Published in July 1993, the article describes in part the findings of Dr. Mufson's research on pneumococcal vaccine and antibody responses of elderly persons.

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G. Ortiz, M. D. (St. Clairsville)

Peripheral Vascular Disease
J. D. Holloway, M. D.

Cardiovascular
A. M. Valentine, M. D.
W. E. Noble, M. D.
Kris Reddy, M. D.
J. Dalal, M. D.
A. E. Frenn, M. D.

Rheumatology
R. Vawter, M. D.

GENERAL SURGERY
E. C. Voss, M. D.
G. Galvin, M. D.

OPHTHALMOLOGY
R. V. Pangilinan, M. D.
D. Simbra, M. D.
H. F. Leeper, M. D., Ph.D.
D. B. Christie, M. D.
Kathryn M. Clark, O. D.

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W. A. Tiu, M. D.
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Med Student Section

Our future is so bright we've got to wear shades

Dear Fellow Medical Students:

Well, I'm not really wearing sunglasses as I write this, but I couldn't be more pleased and excited about three recent events which took place during the WVSMA's Annual Meeting at The Greenbrier that will have a very positive effect on the future of the WVSMA-MSS.

The first significant act was the passing of our resolution to create a Commitee on Graduate Medical Education by the members of the WVSMA's House of Delegates. I was able to attend this year's WVSMA Annual Meeting with four other students and we were welcomed with much encouragement and praise.

During the meeting, I was also extremely pleased to be able to visit the West Virginia School of Osteopathic Medicine with AMA Account Representative Don Foy; WVSMA's Membership Coordinator Donna Webb; and WVSMA-MSS Vice President Nick Cottrell. Our purpose was to recruit students into the WVSMA-MSS and encourage them to establish a component society. Most of the students were very enthusiastic, and as a result of our visit, **28 osteopathic students** have joined the WVSMA-MSS as of September 1.

The third important event that took place at the WVSMA's Annual Meeting was that the board for WESPAC, the WVSMA's political action committee, voted to include medical students and residents as contributors to WESPAC. The board set the contribution levels at $10 for students and $25 for residents. These are the minimum levels, but students and residents are welcome to contribute more if they wish. This new role provides us with the chance to become more politically active, and I hope if you have not yet registered to vote you will do so as soon as possible. **REMEMBER - - THE GENERAL ELECTION IS NOVEMBER 8**. Please take the initiative and help make positive changes in the practice of medicine through the leaders we elect.

In other news, the Huntington and Morgantown component societies recently participated in their respective schools' orientations. The incoming medical students were provided lunch by the WVSMA-MSS and introduced to the WVSMA and AMA. We have been utilizing the Outreach Program sponsored by the AMA to gain new members and increase the strength and voice of the Medical Student Section. Both campuses were very successful with this year's orientations, and we look forward to the input from our new members.

The Medical Student Survey results are still being analyzed. As I stated in the July issue of the *Journal*, our objective is to demonstrate the most important factors and concerns that medical students in West Virginia have about health care reform and rural medicine. We have received approximately 40% of the more than 800 surveys mailed, and the results will also be including the classes of 1998, who received the survey during their orientations. We hope to publish an article in the *Journal* later this year, since many legislators and other state leaders are interested in our results and conclusions.

The WVSMA-MSS is continuing to be recognized more and more as an active and beneficial part of the WVSMA. I attribute much of our success during this past year to Dr. Comerci, who has given us endless encouragement and support. I want to extend my sincerest thanks to Dr. Comerci for always taking the time to speak with us and include us in WVMA functions.

In closing, I would like to welcome all the new WVSMA-MSS members, and say how much we are looking forward to working with Dr. Denny Burton, the new president of the WVSMA.

David C. Faber, MS III
WVSMA-MSS President

4th Annual Vascular Surgery Seminar:

Symposium on Aneurysms

Saturday, October 15, 1994

Featured Speakers:

John J. Bergan, MD
Past President, The Society for Vascular Surgery
Clinical Professor of Surgery, University of California, San Diego
Uniformed Services University of the Health Sciences, Bethesda

Jerry Goldstone, MD
President-Elect of the North American Chapter of the Int'l Society of Cardiovascular Surgery
Professor and Vice-Chairman, Department of Surgery, University of California, San Francisco

Thomas Riles, MD
Professor of Surgery
Director, Division of Vascular Surgery,
New York University Medical Center

Frank J. Veith, MD
President-Elect of the Society for Vascular Surgery
Prof., Combined Dept. of Surgery
Chief, Vascular Surgical Services
Montefiore Medical Center, Albert Einstein College of Medicine, Bronx, New York

Program Director:
Ali F. AbuRahma, MD
Professor of Surgery, Robert C. Byrd Health Sciences Center of West Virginia University, Charleston Division
Chief, Vascular Section, Medical Director, Vascular Laboratory
Charleston Area Medical Center

Location:
Robert C. Byrd Health Sciences Center of West Virginia University, Charleston Division

For more information, please contact
CAMC Continuing Education and Conference Services, (304) 348-9581.

Charleston Area Medical Center

Robert C. Byrd Health Sciences Center of West Virginia University

The long, trembling call sends a shiver down your spine, and then you smile. You've reacted once again to the chilling cry of the tiny screech owl, West Virginia's most common–and smallest–owl.

Screech owls are found throughout West Virginia from woodlots to your own backyard. They nest in hollow cavities and hatch up to five young in late spring. Like all raptors, the screech owl is federally protected.

Dave Jones, master wildlife sculptor and owner of Wildthings Sculpture Studios in Lewisburg, has captured the charm of this diminutive raptor in bronze, the first of an annual series designed to raise funds for West Virginia's Nongame Wildlife and Natural Heritage Program. A limited edition of 200 screech owls will be cast and sold solely to benefit the Program, which has the responsibility of the conservation and monitoring of more than 90% of West Virginia's wildlife. The money raised from the sale will be placed into the West Virginia Wildlife Endowment Fund to work in perpetuity for nongame and endangered species.

Each 10-inch bronze sculpture has a purchase price of $335 (including shipping), of which the West Virginia Wildlife Endowment Fund will receive $130 for the Nongame Wildlife and Natural Heritage account. A tax advisor should be consulted regarding the personal deductibility of this contribution. Each signed and numbered piece will be sold with a certificate of authenticity and a letter confirming your contribution to the future of West Virginia's wildlife.

You may order your screech owl by sending a $335 check for each sculpture to: Wildthings Sculpture Studios, P.O. Box 641, Lewisburg, West Virginia 24901. Telephone: (304) 647-5418.

WESPAC News

We would like to thank the following physicians and alliance members for their contributions to WESPAC:

Physicians

A Dollar A Day Club

**Designates more than $365 in contributions*

Cabell
*Denny Burton
*Phillip R. Stevens
Panayotis Ignatiadis

Kanawha
Ronald Cordell
Sherman Hatfield

Mercer
Charles D. Pruett

Monongalia
Herbert Warden
Vadrevu K. Raju

Raleigh
Ahmed D. Faheem

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Sustainer Members

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Residents

Regular Members - $25
Gold Members - $26 to $150

Gold Members
Kurt Palazzo
David Hess

Alliance Members

Regular Members

Greenbrier
Ramah Jones

Sustainer Members

Central
Anne Ramirez

Harrison
Sue Bryant

New Members

We would like to welcome the following new members to the WVSMA:

Nancy J. Gerber, MD
1502 Harrison Avenue
Elkins, WV 26241

Kourosh Ghalili, MD
3100 MacCorkle Avenue
Suite 411
Charleston, WV 25301

Timothy J. Gore, MD
130 Goff Mountain Road
Cross Lanes, WV 25313

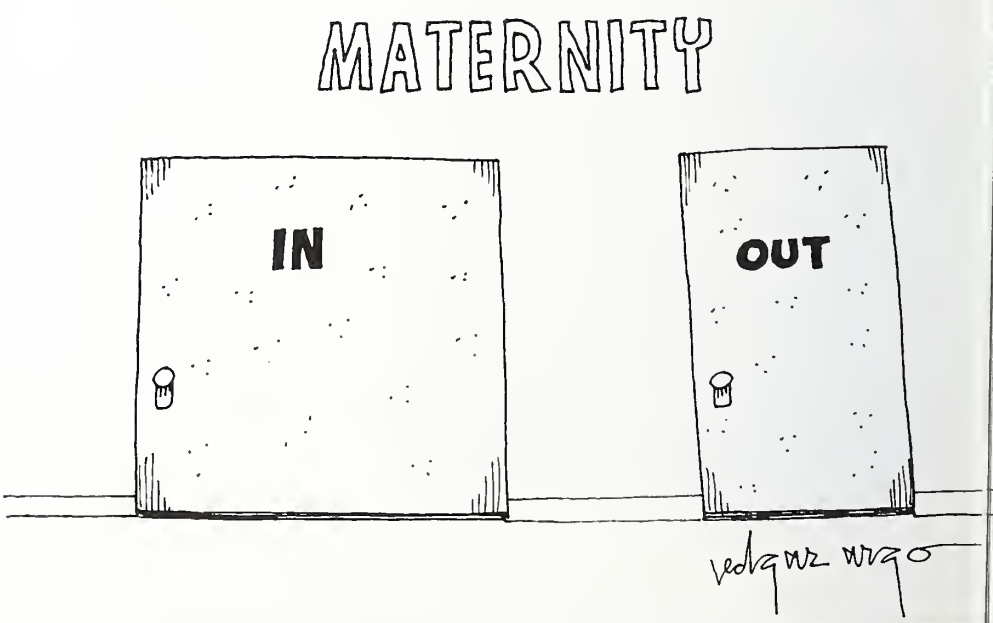
E. Reed Heywood, MD
830 Pennsylvania Avenue
Suite 304
Charleston, WV 25302

Richard W. King, MD
300 Davisson Run Road
Suite 203
Clarksburg, WV 26301

Rosario L. Nadorra, MD
P.O. Box 1998
Williamson, WV 25661

Roger K. Pons, MD
206 Cottage Avenue
Weston, WV 26452

Paramjit Shergill, MD
Oceana Medical Center
P.O. Box 400
Oceana, WV 24870



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October 1994 West Virginia State Medical Association Volume 90 No. 10

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Front Cover

A beautiful fall scene at Ritter Park in Huntington. Photo courtesy of *Mrs. Linda Turner* of Huntington, a past president of the WVSMA Alliance.

SPECIAL SECTION

CONVENTION REPORT '94

Highlights of the West Virginia State Medical Association's 127th Annual Meeting

August 17-20, 1994

The Greenbrier
White Sulphur Springs, West Virginia

We wish to thank the participants of the WVSMA's 127th Annual Meeting. Your commitment and support strengthens the Association and is vital to its continued success.

Among the guests at this year's Executive Committtee/Council Luncheon were (from left) Dr. David Avery, Dr. Rutherford Sims, Dr. John Holloway, Executive Committee members Dr. James Helsley and Dr. Dennis Burton, and Dr. Edward Arnett.

During the Council meeting, Dr. John Markey gestures as he presents a report on the companies who made bids to be the WVSMA's endorsed professional liability carrier.

At the Presidential Reception, Dr. James Comerci, WVSMA president for 1993-94, visits with the President of the Indiana State Medical Association Dr. William VanNess and his wife, and Dr. James Shield Jr., president of the Medical Society of Virginia.

Dr. Phillip Stevens, chairman of the 1995 Annual Program Committee, and his wife, Susan, enjoyed spending time at the Presidential Reception with Mimi Vass, the wife of Rob Vass of Acordia of West Virginia.

In the midst of the Council Meeting, Dr. John Holloway uses a little humor to make a point.

Dr. and Mrs. Henry Hills Jr. of Charleston were happy to be a part of this year's meeting.

Dr. Richard Lang of the Cleveland Clinic delivered this year's Edmund B. Flink Address on *"Prevention in the 1990s."*

"Current Management of Extracranial Cerebral Vascular Disease" was the topic of the Thomas L. Harris Address presented by Dr. John Bergan of the University of California.

WVSMA Executive Director George Rider (right) greets Jim Cates, Steve Brown and Tom Phelps of Medical Assurance of West Virginia; and Tamara Lively and Heather Sipes of Acordia of West Virginia at their booth in the Exhibit Hall.

Dr. Ron Stollings of Madison was the recipient of the Rural Physician of the Year Award, which he dedicated to the memory of his mother, Alma, for her influence on his career.

Claire Spralding of Medicare Operations for Nationwide Mutual Insurance Company was proud to accept the Presidential Citation for her colleague, Deanna Myers of Sissonville, who is critically ill. Deanna is the district Medicare manager for Nationwide, and she was selected for this honor because of her contributions in enhancing health care and the medical profession.

Dr. David Morgan and his wife, Mary Jane, were delighted and honored with the award Dr. Morgan received from Wyeth-Ayerst for his outstanding contributions to community service.

Dr. Robert Pulliam comments on a point made by Dr. Richard Lang following his Edmund B. Flink Address.

Dr. Peter Kim Nelson of New York University Medical Center answers a participant's question about cerebral vascular disease during a panel discussion for the General Scientific Session with Dr. C. Douglas Phillips of the University of Virginia.

Jan Woerth, Ph.D., president of J.K. Woerth, Inc., directed a Lunch and Learn program entitled *"Managed Care . . . Minimizing the Risks,"* which featured input from several visiting dignitaries.

Dr. Russell Biundo of MountainView Rehabilitation Hospital in Morgantown directs a question to one of the speakers during the General Scientific Session on peripheral vascular disease.

Dr. James Comerci delivered a moving Presidential Address during the First Session of the House of Delegates.

AMA President Dr. Robert McAfee enjoyed sharing some political insights with former AMA Delegate Dr. Stephen Ward, who is editor of the *West Virginia Medical Journal.*

WVSMA Finance Manager Sue Shanklin and her husband, Chester, relax after a walk.

Alice Jo Hess of Clarksburg and WVSMA Finance Manager Sue Shanklin fondly look at the WVSMA's historical photos which were on display in the Exhibit Hall.

Exhibitor Chris Ferrell poses with the beautiful quilt her mother made and donated for the raffle which was held for the Family Medicine Foundation of West Virginia.

Dr. Harry Weeks Jr., president and director of the West Virginia Medical Institute, conducted a Lunch and Learn program on *"The Shifting Winds of Quality Oversight"* at this year's meeting.

Dr. Ronald Cordell of Charleston, the WVSMA's new vice president, addressed guests at the luncheon for component and specialty society presidents, past presidents, visiting state presidents and 50-year graduates.

The lucky winners of door prizes from the WVU School of Medicine were Dr. Chinmay Datta and Dr. Darryl Landis.

At the reception hosted by Acordia of West Virginia and Medical Assurance of West Virginia, Inc., Bob Ludwig of Acordia (second from left) visited with Gay Jackson and Beth Hunt of the Marshall University School of Medicine, and Dr. Dennis Burton, the president of the WVSMA for 1994-95.

After the meeting of the Publication Committee, Dr. Stephen Ward, editor of the *West Virginia Medical Journal* (center), was joined by Associate Editors Dr. Robert Marshall, Dr. Harvey Reisenweber, Dr. Joe Jarrett, Dr. David Morgan, Dr. Louis Palmer and Dr. John Hartman for group picture.

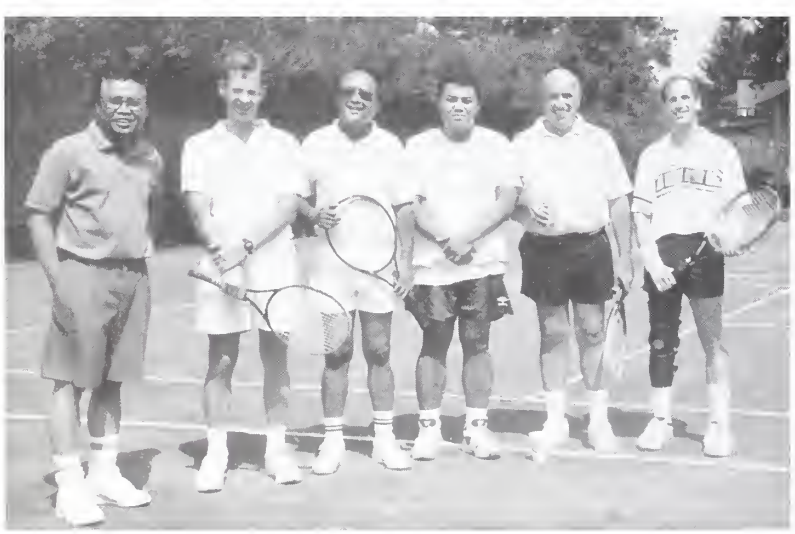
AMA Field Representative Don Foy shows great form during the golf tournament.

The beautiful grounds of The Greenbrier provided some great fishing spots for meeting participants.

Dr. Prospero Gogo, who chaired the tennis tournament, delivers a powerful serve during one of the games.

Sporting their new volleyball t-shirts from Sandoz, Dr. James Comerci, his wife, Lynn, and their daughter, Michele, take time out for a picture after playing in the tournament.

Proudly holding their trophies are golf tournament winners Dr. Jeffrey Stead; Don Foy, AMA field representative; Dr. Martin Murcek, president of the Pennsylvania Medical Society; and Dr. Vincent Townsend.



The "mighty six" to play in this year's tennis tournament were Dr. Constantino Amores, Dr. John Holloway, Dr. Prospero Gogo, Christopher Amores, Dr. William Scaring and Dr. David Waxman.

AMA President Dr. Robert McAfee received a standing ovation from WVSMA leaders after his speech on health care reform during the Second Session of the WVSMA House of Delegates.

AMA Resident Section Delegate Dr. Kurt Palazzo, WVSMA Medical Student Section President David Faber, and WVSMA Medical Student Section Vice President Nick Cottrell were proud to assist with activities during the Second Session of the WVSMA House of Delegates.

New WVSMA President Dr. Dennis Burton was pleased to celebrate his inauguration with his wife, Kathi, his mother, Fawn, and his close friend, Mark McVey. McVey, who is currently starring in *Les Miserables* on Broadway, presented a special evening of musical entertainment at the reception honoring Dr. Burton and the other the newly installed WVSMA and WVSMAA officers.

Dr. John Lavery and his wife, Margaret, were ecstatic about winning a weekend at The Greenbrier at the reception for the new WVSMA and WVSMAA leaders.

Bonnie Fidler, past president of the Kanawha Medical Alliance, accepts the Alliance of the Year Award on behalf of her county from Alice Edwards, chairman of WVSMAA's Awards Committee.

Ginny Reisenweber proudly holds the plaque which the Eastern Panhandle Medical Auxiliary was awarded for having the greatest increase in membership this year. Pictured with Ginny is Sue Bryant, WVSMAA president for 1994-95, who presented the award.

Carole Scaring, WVSMAA president for 1993-94, passes the president's pin to the new WVSMAA President Sue Bryant.

Carole Scaring conducts the WVSMAA's House of Delegates meeting.

AMAA President Barbara Tippens inducts the new WVSMAA officers for 1994-95. Pictured from the left are Joann Cordell, Southwest Regional director; Terry Rojas, Southeast Regional director; Subhra Datta, Northeast Regional director; Lil Gordon, recording secretary; Janet Sebert, treasurer; Amy Ricard, vice president; Linda Elliott, president-elect; and Sue Bryant, president.

Don't be caught in the CME *Cold*

Join us for the 1995 Mid-Winter Seminars and Scientific Conferences

January 19-22, 1995
Radisson Hotel - Huntington

The WVSMA's Mid-Winter Sessions will be held in conjunction with the Fourth Annual Scientific Meeting of the West Virginia Chapter of the American College of Physicians. Call the WVSMA at (304) 925-0342 for more information.

Special topics to be featured include:

Joint Sessions

"Use of Growth Hormone in the Adult and Aging Population"
"New Concepts in Gastro-esophageal Reflux Disease and Ulcer Disease"
"Lessons Learned from Vaccine Use During the Past 40 Years"
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Physician/Public Session

"Health System Reform/Managed Care"

Sexually Transmitted Diseases

"Human Papilloma Virus Infections"
"Treatment of Chlamydia, Gonorrhea and Other Sexually Transmitted Diseases"

Controversies in Medicine

"Screening Mammography"
"Coronary Artery Disease: Medical vs. Surgical Management"

Potpourri of Topics

"Pain Control, Assessment and Treatment: Post-Operative and Terminal"

1994 Resolutions

Resolution 1: (not adopted)

WHEREAS, the State of West Virginia has finally passed a seat belt law, and

WHEREAS, the current law needs to be strengthened in regards to mandatory enforcement and stiffer penalties, and

WHEREAS, a strict reinforced seat belt law has shown to reduce injuries and save lives; therefore be it

RESOLVED, that the WVSMA support a stricter seat belt law.

(WVSMA existing policy already supports stricter seat belt legislation.)

Resolution No 2: (not adopted)

WHEREAS, the State of West Virginia has finally passed a seat belt law, and

WHEREAS, the current law does not require mandatory seat belt use on school buses, and

WHEREAS, the children of this State are one of our most important assets; therefore be it

RESOLVED, that the WVSMA support a stronger seat belt law that requires mandatory seat belts on school buses.

(The committee was not provided with sufficient information to determine the safety of seat belts on school buses.)

Resolution No 3: (not adopted)

WHEREAS, the Federal Government has proposed some type of Tort Reform, and

WHEREAS, the State of West Virginia has not passed any Tort Reform in recent years, and

WHEREAS, The Health Care Planning Commission has proposed Tort Reform for West Virginia, and

WHEREAS, citizens of West Virginia need Tort Reform to reduce the cost of medical care; therefore be it

RESOLVED, that the WVSMA support Tort Reform at the State and Federal level similar to the five principals of MICRA.

(It is already existing WVSMA policy.)

Resolution No 4: (adopted as amended)

WHEREAS, 20% of the cost of medical care is in administrative costs, and

WHEREAS, insurance companies and third party payors have different requirements for Utilization Review, and

WHEREAS, this does not contribute to the quality of patient care; therefore be it

RESOLVED, that the WVSMA support a unified reporting system of Utilization Review of all third party payors, and be it further

RESOLVED, that External Utilization Review Agencies be licensed in this state and thereby be held accountable for the negative decisions that adversely affect patient outcome.

Resolution No 5: (substitute resolution adopted as amended)

WHEREAS, West Virginia has a very high rate of tobacco use, and

WHEREAS, passive smoke inhalation has been shown to cause health problems, including smoking in public places, and

WHEREAS, tobacco use has been shown to be a major cause of health problems; therefore be it

RESOLVED, that the WVSMA support an AMA policy on Federal Tobacco taxes and an increase in WV Tobacco Tax to reduce the overall use of tobacco and its deleterious health effects.

Resolution No 6: (substitute resolution adopted as amended)

WHEREAS, the AMA-MSS has made GME reform a priority in its conversations with Congress; and

WHEREAS, the AMA has developed a Campaign on Workforce Planning; and

WHEREAS, the AMA has established a Task Force consisting of the Council on Medical Education and the Council on Long Range Planning and Development to study, research, and create policy on Physician Workforce Planning Strategies; and

WHEREAS, the AMA has involved medical students in hearings, committee, and council meetings on GME reform issues; and

WHEREAS, Congress has been receptive to AMA-MSS input in meetings in May 1994 between the MSS and Congress; and

WHEREAS, current AMA policy resists the imposition of physician workforce targets (i.e. arbitrary percentage of primary care physicians the must be produced); and

WHEREAS, current AMA policy encourages efforts to increase the proportion of physicians entering and remaining in primary care; and

WHEREAS, WVSMA and AMA publications, mailed to all MSS members who are in good standing, serve as educational tools on GME reform issues; and

WHEREAS, West Virginia medical students from the Marshall University School of Medicine, the West Virginia School of Osteopathic Medicine, and the West Virginia University School of Medicine (Charleston and Morgantown campuses), have been surveyed on their opinions on GME reform issues, as well as representation issues and primary care workforce planning issues; therefore be it

RESOLVED, that WVSMA establish a committee on Graduate Medical Education to include faculty representatives from the Marshall University School of Medicine, the West Virginia School of Osteopathic Medicine, and the West Virginia University School of Medicine, four medical student representatives to be appointed by the WVSMA-MSS Executive Council five resident physician representatives and other representative appointed at the discretion of the WVSMA President to research, study, and review graduate medical education policies in the state of West Virginia. Be it further

RESOLVED, that the Chair of said committee shall be appointed by the WVSMA President. Be it further

RESOLVED, that the budget for said committee shall be recommended by the committee itself for approval by the finance committee of WVSMA. Be it further

RESOLVED, that said committee shall be charged with the following:

1. Research and/or study the current GME policies of WVSMA; and
2. Research and/or study the current GME policies of AMA; and

3. Research and/or study the current GME needs of West Virginia; and
4. Report to WVSMA on its findings at all Council meetings; and
5. Create and adopt policy that opposes medical school admission limitations or controls based on a perceived, though as yet unproven, physician surplus; and
6. Create and adopt policy that favors positive incentives and educational programs that encourage entrance to primary care fields; and
7. Create and adopt policy which firmly opposes arbitrary percentage mechanisms for reaching physician workforce targets.

Resolution No. 7: (substitute resolution adopted)

WHEREAS, the State of West Virginia endured 43 spousal murders in family violence in 1993,

WHEREAS, in 1992, the United States Surgeon General ranked abuse by husbands and partners as the leading cause of bodily injury to women ages 15 to 24, an even greater toll of mental anguish.

WHEREAS, 4 million women in the United States are battered annually,

WHEREAS, week after week, there are news reports in Appalachia of men killing their female partners and, often, themselves,

RESOLVED, that the WVSMA support legislation that provides adequate funding for victims of domestic violence, provides stronger laws shielding victims of domestic violence, provides increased policy training regarding prevention of domestic violence, forbids domestic violence offenders and stalkers from owning guns and subjects domestic violence offenders to mandatory jail terms.

Resolution No. 8: (not adopted)

WHEREAS, The health care costs associated with tobacco use are well documented; and

WHEREAS, Tobacco prices are subsidized by all taxpayers in the form of tobacco price supports requiring non-tobacco users to help pay for these health care cost; therefore be it

RESOLVED, That the WVSMA support legislation seeking elimination of tobacco price supports.

(Fiscal Note: No significant impact.)

(It is current WVSMA policy to support the AMA's compendium regarding tobacco which includes this legislation.)

Resolution No. 9: (substitute resolution adopted)

WHEREAS, There is increasing evidence that secondary smoke is a hazard to the health of those who inhale it (particularly children) in enclosed environments; and

WHEREAS, AMA policies 490.972, 490.982, 490.990, 505.978, 505.979, 505.983 and 505.994 strongly encourage the elimination of smoking in the workplace, restaurants, ballparks, etc; and

WHEREAS, McDonald's recently banned smoking in its restaurants; therefore be it

RESOLVED, That the WVSMA encourage its membership to initiate or join anti-tobacco coalitions in their community.

(Fiscal Note: No significant impact.)

Resolution No. 10: (substitute resolution adopted as amended)

WHEREAS, Pressure from managed care would limit access by excluding physicians from caring for their patients, because of financial contractual obligations, therefore be it,

RESOLVED, that no participating **PHYSICIAN** be subject to termination "without cause," but only after an appeals process including notice, an appropriate probationary period, and failure of the physician to comply with corrective action.

Resolution No. 11: (substitute resolution adopted)

WHEREAS, the majority of the State of West Virginia is federally designated as medically underserved; and

WHEREAS, the Board of Medicine was statutorily created to protect the public health; which health is best served by the availability of competent doctors; and

WHEREAS, the Board of Medicine, having one of the highest rates of discipline in the country, may be perceived as a deterrent to the practice of medicine in West Virginia; and

WHEREAS, it is the perception of some physicians that the procedures, conduct, decisions and sanctions of the Board of Medicine are not always fair and equitable in light of the allegations of misconduct; therefore be it

RESOLVED, that the WVSMA Executive Committee appoint a committee to study the procedures, conduct, decisions, and actions of the Board of Medicine, to improve communications with the Board, and to report to, and make recommendations concerning the Board to the WVSMA on a regular basis.

Resolution No. 12: (substitute resolution adopted)

WHEREAS, 20/40 best corrected vision is required for the privilege of obtaining an unrestricted driver's license in West Virginia,

RESOLVED, that WVSMA support legislation to require appropriate vision testing for renewal of a driver's license.

Resolution No. 13: (substitute resolution adopted)

WHEREAS, the incidence of tobacco use among our youth is increasing, and

WHEREAS, the tobacco industry makes millions of dollars in profits in illegal tobacco sales to our youth, and

WHEREAS, as a result of political contributions from these profits, the tobacco industry has suppressed legislation that would limit the availability of tobacco to youth, and

WHEREAS, the AMA House of Delegates passed Resolution 424 sponsored by the WVSMA that states that the AMA encourage state and local medical societies to determine whether the candidates for federal, state and local offices accept gifts or contributions of any kind from the tobacco industry, and publicize their findings to both their members and the public, therefore be it

RESOLVED, that the WVSMA submit to the AMA House of Delegates at the Interim-94 Meeting a resolution that the AMA determine whether candidates for federal office accept gifts or contributions from the tobacco industry and publicize their findings to their members and the public.

Annual Reports

Committee on Cancer

The members of the Committee on Cancer met for their 1993 annual meeting at The Greenbrier during the WVSMA's 1993 Annual Meeting.

The first order of business was an update on the second year of the grant for the Breast and Cervical Cancer Screening Program presented by Nancye Bazzle, program director of the Cancer Control Program for the West Virginia Bureau of Public Health. She reported that a total of 42,000 mammograms had been performed and 156 cases had received follow-ups, resulting in the diagnosis of 13 cases of cancer. In addition, a total of 11,000 pap smears were performed with 141 colposcopy procedures, and three of these cases had cervical cancer. Bazzle stated that there were 120 screening facilities in West Virginia and that their goal was to have private practice physicians be included as screening providers. She also reported that there are 41 mammography facilities accredited by the ACR in the state.

Patricia Hilton Wilbur, professional education coordinator for the Mary Babb Randolph Cancer Center's Breast and Cervical Cancer Screening Program, reported that the Bureau of Public Health provides continuing education and educational materials to cytotechnologists, pathologists, nurses, radiologic technologists and other health care professionals. She added that more information can be obtained by contacting Cancer Information Services at 1-800-4-CANCER. The committee members then recommended having the information concerning the professional education component of the Breast and Cervical Cancer Screening Program published in the *WESGRAM.*

Beverly Keener, cancer surveillance coordinator for the Bureau of Public Health, commented that 61 hospitals reported cancer cases, 14 of which have tumor registries. A exchange data agreement was ongoing with Virginia, Pennsylvania and Maryland, and the 1994 approved funding for the Cancer Registry was $186,000. The administrative rules of the West Virginia Cancer Registry were to be presented at the fall legislative session. The members of the committee then recommended that any release of information be made only to the reciprocal states.

The meeting concluded after Dr. Mendoza, the committee chairman, announced details about the Fall Cancer Conference and the committee's next meeting at the WVSMA's Mid-Winter Clinical Conference. (*This meeting was later canceled due to hazardous road conditions.)*

The committee's next meeting was held on August 19, 1994 at The Greenbrier. After a review of the correspondence which the committee had been involved with during the past year, Patricia Hilton Wilbur presented a report on the Public Health Nurses Physical Assessment Training Sessions, which were conducted in Charleston in December 1993. She also discussed the CME programs which had been televised by MDTV during the past year, and announced that two CME conferences had been scheduled for 1995. These workshops will be *"Fine Needle Aspiration for Primary Care"* on April 29, and *"Primary Care Perspectives on Women's Health,"* which will be held this winter.

In addition, Wilbur stated that screening information for various cancer-related topics are available through PDQ. Physicians can access this service by calling the Cancer Information Service at 1-800-4-CANCER by FAX machine or through Internet. Two new developments that are now available are a physician reminder system with a distribution of reminder "Cancer Screening" cards, and a computer software program named "Check-Up," for recording cancer screenings.

The next speaker was Beverly Keener, who reported that in 1994 there were 17 hospitals in West Virginia involved in the Cancer Registry with plans for more to be added. An application for the 1995 funding of the Cancer Registry was submitted in the amount of $236,706. She also announced that Dr. Slemp, an epidemiologist, would be joining the West Virginia Department of Health and Human Resources and that the software for hospital cancer registries is available. A summary of diagnosed cancer patients in West Virginia a total of 7,084 cases from 1981 to August 15, 1994 (3,283 males and 3,802 females). The most frequent histologies were adenocarcinoma and squamous cell carcinoma, and the most frequent sites were the lung and bronchus, breast, prostate gland, colon, cervix insitu, urinary bladder, and the rectum and rectosigmoid.

Dr. Mendoza stated that goals and recommendations had been set forth to classify the staging of cancer TNM at the meeting of the Cancer Liaison Physicians of the American College of Surgeons Commission on Cancer, which had been conducted at The Greenbrier on May 5.

The meeting was concluded after the members sent a recommendation to the Executive Committee that they would not meet at the WVSMA's Mid-Winter Clinical Conference unless an issuue needed to be acted upon. Their next meeting is scheduled for The Greenbrier in August 1995, on the same day that the Cancer Coalition of West Virginia will be meeting.

Council

The November 14, 1993, meeting of the Council addressed the following items:

— The 1994 budget was approved. A report on the WVSMA and WESPAC was discussed, and the WVSMAA president delivered a report.

— The financing of the activities of the Medical Education Committee were discussed in light of the increased demand on this group in accrediting various organizations in the state, and the guidelines established by F.D.A. addressing CME.

— The Health Care Provider Tax Act and the difficulties in obtaining information from the Medicaid office were described. It was decided that a final decision on whether the WVSMA will institute a lawsuit against the tax would be made at the Council's January meeting.

— An update on the BC/BS liquidation was presented. It was estimated that when this action is completed, physicians with claims will receive 50 cents on the dollar, rather than the 8-12 cents initially anticipated.

At the meeting on January 23, these items were addressed:

— The Council affirmed the decision to proceed with the litigation concerning the Medicaid provider tax. The suit was to be filed in the next few weeks, and a press release was to be distributed at the time of the filing.

— The legislative program of the WVSMA was discussed and it was endorsed by Council.

— The 1993 financial report was given as approved.

The following items were on the agenda at the Council meeting on April 17:

— The 1994 first quarter financial statement was approved after it was reviewed and the new format was discussed.

— A representative from the AMA explained why WVSMA's delegate representation had dropped from 4 to 3.

— The major issues in the Medicaid litigation were discussed by the WVSMA's attorney. These included the 2% tax, the 30% reduction in payments, and the management of the Medicaid office.

— An update on the BC/BS liquidation was given by the WVSMA's attorney. At that time, the WVSMA had spent $89,535 to protect the interests of all physicians involved in this issue.

— A review of the legislative session was presented and it was reported that the health reform bill by Governor Caperton had not been passed.

— The makeup and purpose of Primary One, Inc., a managed care program consisting of primary care physicians throughout the state was given.

— Action was taken to establish a $500 fee for the annual review of accredited CME sponsors. This action was made due to the increased requirements for maintaining these programs.

The August 17 meeting addressed the following topics:

— Dr. Markey's recommendation that Mutual Assurance of Alabama, Inc., which does business as Medical Assurance of West Virginia, Inc., be endorsed by the WVSMA as the organization's medical malpractice insurer. After a brief presentation and question and answer session, this recommendation was passed by the members.

— The financial report was reviewed and approved. A membership update was also given which showed that the total numbers were the same for 1993 and 1994.

— A review of the status of the Medicaid litigation was given, as well as an update on the BC/BS liquidation.

Committee on Medical Education

The WVSMA is recognized as a provider to accredit intrastate continuing medical education programs by authorization through the Accreditation Council for Continuing Medical Education (ACCME). WVSMA has maintained this role since 1972.

Interest has been expressed in accreditation for sponsorship of CME programs by the following: Bluefield Regional Medical Center, Bluefield; Black Lung Clinic and Primary Care & Recruitment, Charleston; Monongahela General Hospital, Morgantown; Ohio Valley Medical Center, Wheeling; and Wetzel County Hospital, New Martinsville. According to procedure, preliminary questionnaires and information on Essentials and Standards for Commercial Support have been sent to these organizations and hospitals interested in establishing Continuing Medical Education accredited programs.

The nine organizations that have been resurveyed and the one interim report that has been submitted since the last Annual Report are as follows:

Mid-Ohio Valley Continuing Medical Education
Survey: September 8, 1993
Surveyors: Lester Labus, MD; Nancie Divvens; and Shirleen Lipscomb
Award: Continued four-year accreditation with six-month report and two-year interim progress report.

Monongahela Valley Association of Health Centers (Fairmont Clinic)
Survey: September 15, 1993
Surveyors: James Helsley, MD; Nancie Divvens; and Shirleen Lipscomb
Award: Four-year accreditation with two-year interim progress report.

United Hospital Center, Inc.
Survey: September 16, 1993
Surveyors: Anne Hooper, MD; Nancie Divvens; and Donna Webb
Award: Four-year accreditation with six-month report.

Fairmont General Hospital
Survey: February 25, 1994
Surveyors: James D. Helsley, MD; Nancie Divvens; and Shirleen Lipscomb
Award: Full four-year accreditation with annual reports

Pleasant Valley Hospital
Survey: February 22, 1994
Surveyors: Frederick Spencer, MD; Nancie Divvens; and Shirleen Lipscomb
Award: Full four-year accreditation with annual reports

Reynolds Memorial Hospital, Inc.
Survey: March 4, 1994
Surveyors: Terry Elliott, MD; Nancie Divvens; and Shirleen Lipscomb
Award: Full four-year accreditation with annual reports

Jackson General Hospital
Survey: April 7, 1994
Surveyors: Frederick Spencer, MD; Nancie Divvens; and Shirleen Lipscomb
Award: One-year probation with assistance from WVSMA staff

St. Francis Hospital
Survey: April 25, 1994
Surveyors: Daniel S. Foster, MD; Nancie Divvens; and Shirleen Lipscomb
Award: Continued full four-year accreditation with annual reports

American Heart Association-WV Affiliate
Survey: May 10, 1994
Surveyors: Ron Stollings, MD; Nancie Divvens; and Shirleen Lipscomb
Award: Four-year accreditation

WV Academy of Otolaryngology, Head and Neck Surgery, Inc.
One-year interim report submitted

WVSMA currently has these 21 institutions/organizations accredited for Category 1 credit of the Physician's Recognition Award of the American Medical Association:

American Heart Association
Affiliate, Charleston, WV

Beckley Appalachian Regional WV Hospital
Beckley, WV

Broaddus Hospital/Myers Clinic
Philippi, WV

Charleston Area Medical Center
Charleston, WV

City Hospital
Martinsburg, WV

Davis Memorial Hospital
Elkins, WV

Fairmont General Hospital
Fairmont, WV

Jackson General Hospital
Ripley, WV

Mid-Ohio Valley CME
Parkersburg, WV

Monongahela Valley Assoc. of Health Centers
(Fairmont Clinic)
Fairmont, WV

Pleasant Valley Hospital
Point Pleasant, WV

Raleigh County Medical Society
CME Program, Beckley, WV

Reynolds Memorial Hospital
Glen Dale, WV

St. Francis Hospital
Charleston, WV

St. Mary's Hospita
Huntington, WV

United Hospital Center, Inc
Clarksburg, WV

VA Medical Center
Martinsburg, WV

Weirton Medical Center
Weirton, WV

WV Academy of Ophthalmology
Charleston, WV

WV Academy of Otolaryngology
Charleston, WV

Wheeling Area CME Program
Wheeling, WV

The Committee continues to monitor each organization's compliance with the Essentials and Guidelines and the Standards for Commercial Support set by ACCME. The CME Accreditation Director attends all site visits with the survey teams as a source of continuity and uniformity in the application of standards for institutions/organizations.

WVSMA received and distributed the MD Anderson publication on Preparing Objectives for CME Activities to all intrastate sponsors accredited by our program. This was done as a result of the number of inquiries from CME coordinators requesting information/assistance in writing objectives.

A video tape series was ordered from the Alliance for Continuing Medical Education entitled *"Continuing Education in Health Care."* This educational series consists of eight video modules and a workbook. The videos provide important information about how to access individual learning needs and learning styles; increase the relevance of group activities to individual and organizational learning styles; increase the relevance of group activities to individual and organizational learning needs; make learning activities integral to, and a critical component in, improving health care; apply the seven ACCME Essentials; and find and match available resources with identified needs. This series will be extremely helpful in surveyor training.

A CME Workshop, *"CME: Paradigms of the Future,"* was held May 19, 1994, at the Robert C. Byrd Health Sciences Center of WVU in Charleston. Guest speakers were Frances Maitland, ACME Executive Director; Michael I. Gannon, AMA; David Lichtenauer, a CME consultant; Robin Rector, CAMC CME; David Bailey, MU CME; Kari Long, WVU CME; and physician members of the WVSMA, Drs. James L. Comerci, James E. Brick, John W. Traubert, and James D. Helsley. Several WVSMA staff members attended for educational purposes as well as to facilitate the registration and record-keeping pertinent to the workshop. The panel participation and Q & A which followed was well received. Another workshop is planned for May 18, 1995.

The Executive Committee and Council reviewed and unanimously approved an updated version of the Policies and Procedures and CME Mission Statement during their Executive and Council meeting in April.

WVSMA's CME Accreditation Program was resurveyed by the ACCME on July 16, 1994, and we should be notified of the results in October. Robert L. Tupper, M.D., Committee for Review and Recognition, and Judith G. Clark, Ph.D., Director of CME, Florida Medical Association, were the site surveyors. WVSMA's Committee on Medical Education met during the survey.

Nancie Divvens and Shirleen Lipscomb attended the 1994 ACCME Accreditation Workshop, August 12-13 in Williamsburg, Va. In addition, Dr. Traubert and Nancie Divvens both attended the State Medical Society-ACCME Conference in Chicago, Ill., September 9-10, 1994.

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Scientific Newsfront

Alzheimer's disease: A new hope

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Abstract

Until recently, the diagnosis and treatment of Alzheimer's disease was limited. This article describes the outcome of new research and advances in the pharmacological treatment of this disease, especially the use of Cognex (tacrine). It also reports on a multicenter study of tacrine we participated in with patients at Raleigh Psychiatric Services, Inc. in Beckley.

Introduction

In a recent study of 5,000 men and women, it was shown that memory loss over a period of 35 years is common, but by no means inevitable. The rate of memory decline varies for men and women, with the greatest loss being in basic math for both sexes, and the least in spatial orientation for men and inductive reasoning in women (1,2).

However, in Alzheimer's disease there is progressive loss in memory, intellect, attention, orientation, visual-spatial function and problem solving (3,4). Deterioration, though variable, usually occurs in a stepladder fashion; things learned last are the first to be forgotten.

Even though diagnosed clinically, a definitive diagnosis of Alzheimer's can be made only by brain biopsy. However, with a multidisciplinary approach CT, MRI, lumbar puncture, EEG, and psychological testing such as the Mini-Mental State Examination, Bender, Blessed Dementia Scale and the Clock Test, this disease can be diagnosed with 90% clinical accuracy (3). There are no known biological markers to diagnose Alzheimer's, but in September 1993, a skin culturing test for detecting it was first described (5). In addition, many scientists believe that the hippocampus is the first area affected by Alzheimer's since there is an excess atrophy which can be detected early in an expert neuroradiological exam on either CT or MRI.

It is estimated that 9% of the individuals over 65 and 10% of the population over 75 suffer from Alzheimer's (5,6). This disease accounts for 55%-60% of all the dementias, and is possibly related to an autosomal dominant genetic inheritance (6), with mutations on chromosome 21, 21q or 41q (in early onset) and on chromosome 19 (in late onset) (7,8).

The role of Apo E

The role of Amyloid and Amyloid Precursor Protein, enriched in neurons, is critical in the development of Alzheimer's, though the mechanism is not clearly defined (6,9,10). Apo E, involved in mobilization and redistribution of cholesterol, transfers amyloid to the brain where it accumulates extracellularly in the amyloid plaque; intracellularly in the neurofibrillary tangles, forming deposits that strangle nerve synapses (5,8).

Present in chromosome 19, Apo E is found in three genetic variants as E2 (2%), E3 (78%), and E4 (15%) (7,11,12,13,14). Normally, the Apo E3 allele is inherited by 90% of the population, and 60% inherit two copies of the allele. More than half of the individuals who develop Alzheimer's inherit the E4 allele.

Roses, Strittmatter and Salvensen at Duke University studied 234 individuals in 46 families and found the following:

1. If Apo E4 is inherited from both parents, the chance of developing Alzheimer's by age 68 is increased nine times.
2. If Apo E4 is inherited from one parent, the chance of developing Alheimer's at age 77 is increased three times.
3. If no Apo E4 is inherited, the average age of onset of Alzheimer's is 85 years.

This study estimated that 2% of the population falls into the high risk category, E4/E4, and 64% into the E4 category (12,13,14). It further supports that position that Alzheimer's is a syndrome with various subtypes of varying etiology with considerable overlap.

As such subtypes emerge over the next decade, specific behavioral, psychosocial and pharmacological interventions to target each subtype will need to be developed. The new hope for Alzheimer's victims is that future research may focus on the development of drugs which will short circuit the process in which Apo E4 affects the neurofibrillary plaques and tangles. Early diagnosis and preventive treatment may be offered through blood tests designed to identify Apo E4 carriers.

Pharmacological treatment

Although disappointing in the past, pharmacological treatment of Alzheimer's is proving to have some effectiveness. Drugs such as lecithin, hydergine, ACE inhibitors, piracetam (nootropic), and tacrine (aminoacridine), may modestly improve cognition function and slow the progression of the disease though they do not reverse the course (15).

To evaluate the effectiveness and potential hepatotoxicity of tacrine in the treatment of dementia of the Alzheimer's type, we participated in a multicenter study with patients at Raleigh Psychiatric Services, Inc. This study was conducted from the summer of 1992 until November 1993, when this drug was released by the FDA.

Initially, during our early clinical trials, tacrine was not as effective in the treatment of Alzheimer's as was expected. Further clinical experience, however, indicated that this drug is more effective if doses greater than 80 mg./day given for at least 160 days, are taken either alone or in combination with other drugs such as eldepryl. We have found tacrine effective in approximately 25%-40% of the patients receiving the drug.

Currently, all our patients at Raleigh Psychiatric Services, Inc. are administered the Mini-Mental Status Examination and Clock Test prior to starting on tacrine. These tests are repeated periodically to assess any objective, cognitive improvement, which is coordinated with the subjective reporting by the caregivers, the latter being more important. A CT scan, EEG, MRI, and other tests are also conducted prior to prescribing this medication in order to rule out an organic basis of the dementia. Alzheimer's patients and families are informed of the risks and benefits of the drug prior to initiation, so the decision to start the drug is collective.

Tacrine must be carefully monitored. Most common side effects are transitory and include GI disturbance (anorexia, diarrhea), lowered seizure threshold, psychomotor agitation, and increased ALT levels as a sign of liver involvement. Through use of home health nurses, weekly ALT levels for the first 18 weeks should be performed, even as the dosage is increased, from 40 mg./day to a maximum of 160 mg./day at six-week intervals. When ALT levels are greater than three to five times the upper limit, the tacrine dose is decreased by one capsule (10-40 mg./day) depending on the dosage being administered. After the ALT returns to normal limits, the dosage may again be titrated upwards, though more slowly. Once a patient is stabilized on an adequate dosage (80-160 mg./day), monitoring ALT levels is left to the discretion of the physician usually at intervals of every month to three months.

Sudden stoppage of tacrine should be avoided since it may result in rapid mental deterioration and may simulate stupor or even cerebrovascular accident. During the clinical trials, patients who were hospitalized and taken off tacrine suddenly became confused, incoherent and lethargic. When tacrine was reinstituted, the patient returned to their previous level of functioning.

In our experience, initial agitation, which may cause concern in families, has been found to be a positive, prognostic indicator that the families should be forewarned of and the drug should not be stopped as a result. Depending on the clinical needs of the patient, improvement may be made through a judicious combination of antidepressants (preferably SSRI), antipsychotics or short-acting anxiolytic. Conventional antipsychotics are not well tolerated and, we have found that in selected cases, small doses of Risperidone or Clozapine can be fairly effective and well tolerated.

Conclusion

The current research and pharmacological treatment of Alzheimer's does not promise a cure or panacea of treatment, however, it can give new hope for families and victims of this disease by slowing its progress. Future research to identify various subtypes and developing those specific treatment modalities and prevention, such as those suggested by Schiae (1), offer a new hope for the population at large, especially those at high risk (i.e., the aged with a positive F/H).

The characteristics outlined by Schaie for predicting a person's mental function as they age are as follows:

1. A high level of ability in reading comprehension or verbal fluency.
2. A successful career or some other active involvement through life and continuing keen mental interests after retirement.
3. Having a flexible attitude in middle age is also a promising indicator -- less mental decline in people who adapt easily to change, i.e. those who like new learning and enjoy going to new places.
4. Simply living with someone with the characteristics mentioned in the first three items is beneficial over the course of long marriages. Spouses' scores on mental abilities tend to converge, with the brighter partner elevating the other's score.

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A post-thyroidectomy convulsion: An unusual presentation of chronic hypoparathyroidism

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Abstract

A 59-year-old woman with previously undiagnosed hypoparathyroidism presented with a tonic-clonic seizure 38 years after thyroidectomy. This case is unusual because of the initial presentation, but also unique because it is the longest latency period between surgery and presentation in recent literature.

Introduction

Convulsive disorders are common among the general population, affecting as many as 2 million Americans during their lifetimes (1). However, there are many medical conditions in addition to epilepsy which may present with seizures, such as tumors, endocrine disorders, and substance abuse and withdrawal.

When a patient presents directly with a new onset seizure, a complete history and physical, as well as basic laboratory testing should be performed. This includes electrolytes, calcium, magnesium, phosphorous, and, if appropriate, drug screening. This testing will prove immediately valuable in the diagnosis and treatment of any patient's underlying cause of seizure, and in the patient's case we will be describing, showed chronic hypoparathyroidism.

Adult hypoparathyroidism is most commonly iatrogenic, secondary to surgery involving the thyroid or parathyroid glands (2). The damage to the gland or to the vascular supply lowers serum levels of parathyroid hormone and calcium with secondary changes in magnesium and phosphorous (3). The hypocalcemia may be manifested as changes in neuromuscular excitability or as irritability of the central nervous system. This condition can present years after thyroid or neck surgery.

In this article, we describe a patient with hypoparathyroidism who initially presented with a single tonic-clonic seizure, 38 years after thyroidectomy. This case was unusual because of its initial presentation, but also unique because it is the longest latency period between surgery and presentation in recent literature.

Case report

A 59-year-old woman arrived at the Emergency Department at the Veterans Administration Medical Center in Huntington with complaints of nausea, several bouts of vomiting and diarrhea, shortness of breath and weakness over the previous three days. Her medical history included hypertension for which she had been treated for eight years, gout, and a history of alcohol abuse, which had become progressively worse over the past few years. She did state, though, that for the two weeks prior she had not consumed any alcohol, and also had never gone through alcohol withdrawal, and had never experienced a previous seizure.

This patient had undergone a thyroidectomy for treatment of toxic goiter 38 years previously. Her medications included allopurinol, diltiazem, levothyroxine, and triamterene/hydrochlorothiazide.

On physical examination, her vital signs were temperature 100.5 F, pulse 119, respirations 20, and blood pressure 146/97. She was oriented but lethargic. There was no apparent injury to the head; the fundi were not seen due to mild cataracts. Her neck was supple with a thin transverse scar; lungs were clear to auscultation. In addition, her abdominal exam and neurological exams were normal, and her deep tendon reflexes were hyporeflexive in all four limbs.

A complete chemistry panel and a complete blood count were ordered. While this patient was in the Radiology Department for a chest X-ray, she experienced a single brief tonic-clonic seizure. When she was returned to the Emergency Department, she was immediately given a loading dose of intravenous phenytoin and additional tests (drug screen and magnesium, calcium, phosphorus and serum alcohol levels) were ordered.

Initial laboratory results were: sodium 136, potassium 4.2, chloride 98, bicarbonate 25, BUN 8.0, creatinine 0.8 and glucose 122. Serum calcium was 4.8 (8.5-10.5 mg./dl.), phosphorous was 6.8 (2.5-4.5 mg./dl.) and magnesium was 2.0 (1.7-2.4 mg./dl.). Urinalysis was within normal limits. Albumin was 2.9, LDH 544, SGOT 164, GGT 534, alkaline phosphatase 195 (30-100 U/l); values which can be explained by the patient's previous alcohol use and poor nutritional intake.

Her complete blood count was WBC 10.1, with a normal differential; hemoglobin 13.8. Thyroid function tests showed TSH 4.4 (0.3 - 5.0 mIU/ml.), T4 4.9 (4.5 - 12.0 µg./dl.), free thyroxine index 1.42 (0.99 - 4.08), T3 uptake 29 (21 - 34%), which were all within normal limits. Toxicology screen showed no recent use of barbiturates, benzodiazepines or tricyclics, and her serum alcohol level was was zero.

The results of this patient's EKG showed a sinus tachycardia rate of 110, normal QT interval 0.36. Her chest X-ray revealed no infiltrates of the lungs and normal heart size. A CT scan of the head without contrast showed no evidence of ischemia, bleeding or mass effect. Further studies after admission showed urine calcium 68 mg./24 hr. (100-300 mg./24 hr.), parathyroid hormone C-terminal < 0.3 ng./ml. (significantly below normal) with a simultaneous serum calcium of 6.3 mg./dl.

Immediately after the serum calcium level was reported, the presumptive diagnosis was hypoparathyroidism, and the patient was treated with a 10% solution of calcium gluconate at 5.5 ml./hr., magnesium sulfate, 1.0 g. IV over 15 minutes, and aluminum hydroxide by mouth. After initial therapy and 14 hours after admission, an EEG was performed which showed non-specific generalized slowing of waves. Phenytoin was continued during her hospital stay until the serum calcium reached acceptable levels to prevent further seizure activity.

She had no other seizures during her admission and was successfully controlled with calcium carbonate 1.0 g. (elemental calcium) tid, magnesium chloride hexahydrate 130 mg. tid, aluminum hydroxide 3 g. tid (all by mouth) and was discharged on the fifth hospital day. Vitamin D analogs were not given because the serum calcium was stable at 7.3 mg./dl. at

discharge, and further management of hypocalcemia was to be completed as an outpatient.

Discussion

This case report is unusual for two reasons: the prolonged latency from the time of surgery to development of hypoparathyroidism and the presentation with seizures.

Dimich and colleagues reported their experiences with adult hypoparathyroidism in 21 patients, 16 of whom presented with symptoms of hypoparathyroidism within one year of surgery. The remaining five presented between one and 19 years after surgery (4). In addition, Petch described a case that presented 27 years postsurgery (5), and Blancharde reported a case which presented 33 years after thyroidectomy (6). Our patient had undergone her thyroidectomy in 1953 for toxic goiter, and presented with hypoparathyroidism 38 years after surgery, so her latency period is the longest cited in recent literature.

Usually, hypoparathyroidism presents in adults initially as muscle spasms, carpopedal spasms and facial grimacing. In the experience of Dimich et al, the most common presenting symptom is carpopedal spasm (4). Only 4% of patients with postoperative hypoparathyroidism present with convulsions, compared to 70% of patients with idiopathic hypoparathyroidism (4).

Due to her history of alcohol abuse, it was initially assumed that this patient was suffering from withdrawal ("rum fit"), which may first present as a brief, single generalized tonic-clonic seizure. However, this is unlikely since she and family members reported that she had consumed no alcohol for at least two weeks.

This patient's complaints of weakness and lethargy are attributable to hypoparathyroidism. She also had coarse, dry skin and hair which are often found in hypothyroidism (even though she was receiving thyroid replacement and her thyroid function tests were normal), but which are also described in hypoparathyroidism. Another of her symptoms was diarrhea, which is a common finding in hypoparathyroidism (7).

It is likely that this patient had suffered from hypocalcemia for some time. It can be speculated that a combination of factors including acute viral gastroenteritis, poor nutritional intake (as evidenced by her low serum albumin), post-menopausal state or other factors contributed to her severe hypocalcemia, eventually leading to her convulsion. Studies by Endres have shown that dietary calcium intake decreases in the elderly and that elderly women have elevated urinary calcium excretion, which is presumably related to reduced levels of estrogens after menopause (8).

When an adult presents with an initial seizure, it is important that a full evaluation be completed. The diagnosis of hypoparathyroidism should be considered in all patients with a thyroidectomy scar. Convulsions caused by hypocalcemia may be fully corrected by treating the underlying cause, without long-term anticonvulsant therapy (3,9).

Acknowledgment

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Hantavirus Pulmonary Syndrome

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Abstract

An outbreak of Hantavirus Pulmonary Syndrome (HPS) occurred in the western U.S. in 1993. This outbreak was surprising because serious disease due to hantavirus had not been reported previously in the U.S., and hantavirus had not been documented to cause significant pulmonary disease. Epidemiologic investigation discovered a novel strain of hantavirus as the etiologic agent of HPS. The Centers for Disease Control (CDC) proposed the name of Muerto Canyon virus for this novel hantavirus, which is transmitted through aerosolized excreta of infected rodents. HPS begins with a prodrome of fever, myalgia, and respiratory symptoms followed by the acute onset of respiratory distress. Since HPS has a mortality of 60%, early recognition is important so that supportive treatment can be initiated promptly. Intravenous ribavirin is investigational therapy and can be obtained through the CDC in Atlanta.

Introduction

The Hantavirus Pulmonary Syndrome (HPS) (1-4) was one of several emerging infectious diseases that posed significant challenges for the U.S. medical community during 1993. An outbreak of HPS, which was centered in the Southwestern states of New Mexico and Arizona, was arguably the most interesting emerging infectious disease of last year. This HPS outbreak was the first recognized clinical syndrome caused by hantavirus in which significant pulmonary disease occurred, and was the first documented outbreak of significant human disease due to hantavirus in the United States.

This paper presents an overview of the 1993 HPS outbreak and discusses the epidemiology and the very rapid and effective public health response. It also reviews previously known clinical syndromes associated with hantavirus and emphasizes the clinical manifestations, treatment, and prevention for this disease.

The 1993 HPS outbreak

The initial cluster of cases of HPS was recognized and reported by Dr. B. Tempest who was working for the Indian Health Service. He reported that on 5/5/93, a 19-year-old healthy male Navajo long distance runner died after he was brought to Gallup Indian Medical Center in full cardiopulmonary arrest. This patient had clear respiratory secretions with a negative gram stain, and his chest X-ray (CXR) had shown diffuse bilateral infiltrates consistent with adult respiratory distress syndrome.

Two days prior to this patient's death, the index case had been seen in another Indian Health Service clinic. This first patient had experienced a respiratory illness with fever (102°), non-productive cough, clear lungs to auscultation, negative CXR, and elevated serum lactic dehydrogenase (LDH). He had been treated empirically with erythromycin and amantadine for two days without improvement and then experienced acute respiratory failure.

The first patient's fiancee had died from a similar illness five days prior to his death. Microbiologic and serologic studies were negative for *Yersinia pestis*, the etiologic agent of pneumonic plague which is endemic to the Four Corners area (New Mexico, Arizona, Utah, and Colorado).

Response by Public Health

Dr. Tempest's colleagues in the Indian Health Service informed him of three similiar cases of an acute febrile respiratory syndrome, so he reported the initial cluster of cases to the New Mexico Department of Health (NMDOH) on 5/14/93. The NMDOH began a site investigation on 5/17, and serum and tissue samples were sent to the Centers for Disease Control (CDC) on 5/21.

CDC staff members came to Albuquerque on 5/29, and by 6/4, they had identified a previously unknown hantavirus as the possible etiology by serologic results. Their initial report was published on 6/11 (1), and on 6/18, the CDC reported confirmation of hantavirus as the etiologic agent with the use of the polymerase chain reaction (PCR) (2). The CDC then published Interim Recommendations for Risk Reduction on 7/30 to prevent further cases of HPS (5).

By the end of 1993, the CDC had identified 53 persons with confirmed cases of HPS (4). A majority of these cases were young adults, 57% were male, and 49% were American Indians (Table 1) (4). The cases occurred in residents of the 14 states west of the Mississippi River (Figure 1) (4), and some of the confirmed cases occurred prior to 1993 (Figure 2) (4). The mortality rate for HPS was 60% (4).

Hantavirus syndromes

Hantaviruses are RNA viruses that belong to the Bunyaviridae family. Other genera of the Bunyaviridae family include bunyaviruses which cause California encephalitis, phleboviruses which cause Rift Valley fever, and nairoviruses which cause Congo-Crimean hemorrhagic fever. The routes of transmission for these three genera of Bunyaviridae are insect bites.

In contrast, transmission of hantaviruses does not require or utilize insects, but involves rodent reservoirs and aerosolized or airborne rodent excreta. Hantavirus causes asymptomatic infection in the rodent reservoir but serious disease in the human host.

Hemorrhagic fever with RS

Hemorrhagic fever with renal syndrome (HFRS) is the only previously described clinical syndrome caused by hantavirus (6-9). HFRS was initially described as Korean Hemorrhagic Fever (KHF) when caused by the Hantaan virus or the Seoul virus in Korea, or nephrotica epidemica when caused by the Puumala virus in Europe (7).

Korean Hemorrhagic Fever

KHF is a viral infection acquired from rodents in Asia north of the Himalayas in Korea, Eastern Siberia, and China, which can cause severe disease manifested by shock and renal failure with a 10% mortality (6-8). KHF mostly affects rural civilians and military personnel stationed in rural areas, and there are 100,000 cases per year in China (9).

This disease was first reported in the 1930s by Russians in Far Eastern Siberia, and then it affected Japanese military personnel during the Manchurian campaign of World War II, and 3,000 U.S. troops during the Korean War (7). From 1960 to 1990, there were less than 10 cases per year in American troops in Korea except for an outbreak of 14 cases during a training exercise in 1986 (10).

The etiologic agent of KHF was isolated in 1978 near the Hantaan river in South Korea (11). The World Health Organization adopted the terminology of Hemorrhagic Fever with Renal Syndrome (HFRS) in 1982 for both KHF and nephrotica epidemica, the similar syndrome occurring in Europe (7).

The clinical manifestations of HFRS occur in five stages (6-8). The first or febrile stage begins with the abrupt onset of fever, chills, lethargy, and an erythematous flush of the head, neck, and trunk. During days 3-5, petechiae, hemorrhage, progressive leucocytosis, and proteinuria appear.

The second or shock stage begins on day 5 with hypotension, proteinuria, and thrombocytopenia of less than 70,000/cu mm. This stage is the most serious and requires intense supportive care in order to prevent fatalities.

During the third or oliguric phase, the patient recovers from hypotension and experiences normotension or hypertension. Oliguria then occurs, resulting in a rapid rise in BUN, hyperkalemia, hyperphosphatemia, and hypocalcemia. Hemorrhagic manifestations, such as gross hematuria, subconjunctival hemorrhage, hemoptysis, and gastrointestinal bleeding also appear, and some patients experience central nervous system manifestations including restlessness, hallucinations and seizures. Pulmonary manifestations are infrequent and insignificant.

The fourth or polyuric phase occurs during days 7 to 10 when diuresis signals improvement and the complications resolve. Convalescence occurs during the fifth phase.

Epidemiologic studies of KHF in American military personnel demonstrated that the troops at risk slept near high grass and scrub brush. These troops would be most likely to be exposed to the aerosolized rodent excreta.

Hantavirus infection in the U.S.

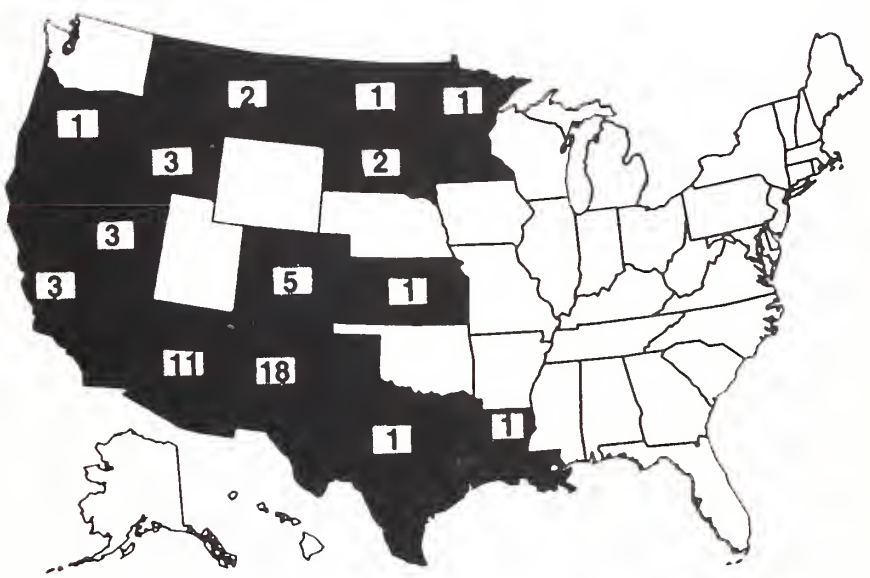
Acute renal or pulmonary manifestations of human hantavirus infection in the United States had not been described prior to the 1993 HPS outbreak, but hantavirus infection in

Table 1. Characteristics of the 53 persons in the U.S. reported with hantavirus pulmonary syndrome from May - December 1993

Characteristic	Total	Deaths No.	Deaths (%)	Relative risk	(95% CI*)
Age (yrs.)					
<20	7	4	(57)	Referent	
20-29	14	7	(50)	0.9	(0.4-2.0)
30-39	18	14	(78)	1.4	(0.4-2.0)
≥40	14	7	(50)	0.9	(0.4-2.0)
Sex					
Female	23	13	(57)	Referent	
Male	30	19	(63)	1.1	(0.7-1.8)
Race					
American Indian	26	15	(58)	Referent	
Other ‡	27	17	(63)	1.1	(0.7-1.7)

* Confidence interval.
‡ Non-hispanic white, Hispanic, and non-Hispanic black.
Source: CDC. MMWR 1994;43:45.

Figure 1. Number of reported confirmed cases of hantavirus pulmonary syndrome – United States, 1993



Source: CDC. MMWR 1994;43:46.

American rodent populations had been well documented (12-17), as well as cases of infection without illness (18,19).

In West Virginia, there have been cases of both hantavirus infection in the state's rodent population (16,17), and in our residents (18). In addition, a recent report found that 6.5% of patients in Baltimore with hypertensive renal disease but no prior history of HFRS were seropositive for hantavirus compared to a seroprevalence of 0.25% for the reference group (20).

Hantavirus Pulmonary Syndrome

A NMDOH toxicologist noted a major infestation of mice during the site visit to the index patient's home during the outbreak in New Mexico in May 1993. Serologic studies showed that the primary reservoir for the 1993 HPS outbreak was the deer mouse, *Peromyscus maniculatis* (3). Other rodents with serologic evidence of the New Mexico strain of hantavirus include the piñon mouse, *P. truei;* the brush mouse, *P. boylii;* and western chipmunks, Tamias species (3).

Transmission of HPS to humans occurs primarily by inhalation of aerosols of rodent saliva or excreta, or by the ingestion of contaminated food or water; rarely is there direct inoculation onto broken skin or conjunctiva, or is it transmitted by rodent bites. In the New Mexico site visit, no illness was observed in the rodent hosts, and there was no evidence of human to human transmission.

Molecular epidemiology

By serologic evaluation, the New Mexico strain of hantavirus was most closely related to the Prospect Hill strain of hantavirus and less closely related to the Seoul, Hantaan, and Puumala viruses (3). The Prospect Hill strain has been found in the native rodent population of the forested areas around Frederick, Md. (12), and nucleic acid sequencing studies confirmed that the New Mexico strain was most similar to the Prospect Hill strain (21).

The Muerto Canyon virus has been proposed as the name for the New Mexico, or Four Corners, strain of hantavirus which causes HPS (4).

Clinical manifestations

During the New Mexico outbreak, CDC officials established screening criteria for HPS as part of their epidemiologic investigation (3). One set of inclusion criteria included a febrile illness (temp ≥ 101 F (38.3 C)) in a previously healthy person with unexplained adult respiratory distress syndrome or bilateral interstitial infiltrates with a requirement for supplemental oxygen. An alternative set of inclusion criteria included an unexplained fatal respiratory illness with autopsy findings of noncardiogenic pulmonary edema.

Exclusion criteria for HPS were a predisposing medical condition, such as malignancy, immunodeficiency, immunosuppressive therapy, or severe pulmonary disease, and an acute illness that is a likely etiology for ARDS, such as trauma, seizures or aspiration, sepsis, respiratory syncytial virus (RSV), influenza, or legionellosis (3). Confirmation of HPS had to be made with at least one specimen (serum and/or tissue) available for lab testing and one of the following three tests positive for hantavirus: serology (detectable IgM or rise in IgG), polymerase chain reaction (PCR) for RNA, or immunochemistry for antigen (3).

The patients in New Mexico had a prodrome of fever, myalgia, and respiratory symptoms followed by an abrupt onset of acute respiratory distress (3). Other symptoms included headache, abdominal pain, nausea, and vomiting. Laboratory abnormalities included hemoconcentration in 76% of the cases which progressed during the period of hospitalization; thrombocytopenia in 71%; and leucocytosis with an increase in bands, hypoalbuminemia, and lactic acidosis (3). All patients developed bilateral pulmonary infiltrates within two days of admission, and gross pathology revealed serous pulmonary effusions and heavy edematous lungs (3).

Microscopic examination demonstrated interstitial infiltrates of mononuclear cells in alveolar septa, congestion, and septal and alveolar edema (3). Cellular debris and neutrophils were not prominent. Immunohistochemistry detected hantavirus antigen in the endothelial cells of most organs with heavy accumulations in the lungs (3).

Treatment

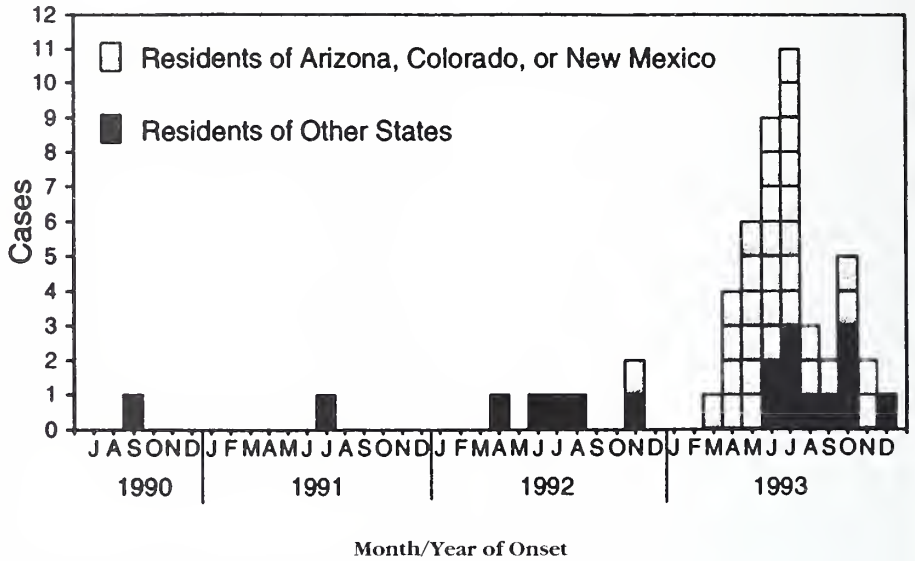
Treatment of HPS involves mainly supportive care with supplemental oxygen, fluid management, and vasopressor agents or cardiotonic drugs (3). Caution should be taken to avoid overhydration (3).

Intravenous ribavirin has been shown to be effective in hantavirus HFRS (22) and is investigational in HPS (3). It can be obtained by phoning the CDC Ribavirin Officer of the Day on weekdays at 404-639-1510 and on weekends/evenings at 404-639-2888 (3).

Prevention

The prevention of HPS depends upon the realization that hantavirus infections in humans occur primarily in adults who become exposed to

Figure 2. Number of confirmed cases of hantavirus pulmonary syndrome, by month and year of onset and by state – July 1990 - December 1993*



* Does not include one case from 1980 reported in California.

Source: CDC. MMWR 1994;43:46.

rodent excreta during domestic, occupational, or leisure activities (5). Some of the activities that place people at risk include planting or harvesting field crops, occupying previously vacant cabins or other dwellings, disturbing rodent-infested areas while hiking or camping, and residing in areas in which rodent populations have shown an increase in density (5).

Specific recommendations for risk reduction through environmental hygiene practices have been described by the CDC (5).

Summary

An outbreak of HPS occurred in the western United States in 1993. This outbreak was the first reported outbreak of serious disease due to hantavirus in the United States and the first occurrence of significant pulmonary disease due to hantavirus. The etiologic agent of HPS is a novel strain of hantavirus with the proposed name of Muerto Canyon virus.

HPS is transmitted through aerosolized excreta of infected rodents and the symptoms of this disease include fever, myalgia, and respiratory symptoms followed by the acute onset of respiratory distress. Treatment is mainly supportive, but intravenous ribavirin is being investigated and can be obtained through the CDC. There is a 60% mortality rate.

Prevention of HPS involves reducing exposure to rodent excreta in persons whose occupational, domestic, or leisure activities place them at risk.

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We closely examined Medical Assurance/Mutual Assurance's philosophies and found them to be congruent with those of the physicians in out state. Mutual Assurance has more than 17 years experience in professional liability insurance and has demonstrated to us the need for the **involvement** of West Virginia physicians in their program. Our representatives have attended meetings of Mutual Assurance's Claims and Underwriting Committees, and have seen them put into action their philosophy of physician involvement. There is a strong bond to organized medicine, and we will be asking many of you to serve in various capacities to help insure that this program mirrors your needs and desires.

No relationship is built without a solid foundation. In this case, the final cornerstone of the foundation is Medical Assurance's long-term **commitment** to you, the WVSMA, and to the goals we have set forth for ourselves.

Mutual Assurance was forged in the fire of crisis during the mid 1970s when premiums increased dramatically. While at the time there were more doubters than believers, the ensuing years have proven that the founding physicians of Mutual Assurance made the correct, albeit tough choices: Charge an adequate premium in order to guarantee the company's long-term future, defend claims aggressively and avoid unreasonable, unwarranted settlements which only "feed the tiger;" and finally, work with and through organized medicine to ensure that physicians have a true voice in the program and company that protects them.

Medical Assurance stands today as the proof that the founding philosophy works exceedingly well. We have chosen a company that brings us undisputed financial **stability** and **strength,** is committed to your **involvement** in its program, and has made a long-term **commitment** to West Virginia and its physicians. After a long and difficult search, I can tell you that combination was exceptionally hard to find.

We believe the WVSMA has chosen wisely, now it's time for you to choose wisely as well!

Dennis M. Burton, M.D.

Politics and Medicine

If Medicine has ever been the recipient of strong encouragement to be politically active, that encouragement has been received this year. Oh yes, we have had AMPAC and the various state pacs in the past and some of us have actually contributed time and money to efforts stirred by such as these. It seems obvious, however, that a significant majority of us have never been convinced that the expense and effort would be in anyway availing, even though the stated aims and goals were undeniably attractive.

One might be inclined to attribute this gift of encouragement to the Clintons who certainly catapulted the profession into what has been a life or death struggle. The real revelations, however, seem to be the allies we have discovered -- allies willing to go to the mat in defense of those things we have held dear but feared others might not appreciate. It is undeniable now -- we do have political power and it is possible for us to set and to reach political goals. But these efforts need to be made in conjunction with friendly allies.

One hardly needs to point out that in the process of all this we have assumed the obligation to examine at least some of the issues that might be important to our new found friends. In that regard, it has always been surprising to note the number of physicians in this state registered and voting Democratic. We have heard the time honored argument in explanation of this phenomenon that if you want to have any effect at all on the political process in West Virginia, you must vector things within the Democratic party because of the impotence of the Republican party in this state. It seems to us, however, that such an argument simply perpetuates a very unfortunate and very undesirable condition at the ballot box which makes it virtually impossible in many cases to remove elected officials badly in need of being removed. Besides that, it is certainly clear that our intra-Democratic party efforts have gotten us precious little other than contempt from our Democratic legislators in years gone by.

One also might note that physicians as a group generally identify themselves as religiously inclined or, at least, God-fearing and church-going individuals. In this capacity, we are maligned along with all others identified as members of the "religious right," a designation connoting certain intolerant, perhaps fascistic tendencies. "Right Wing" is an epithet bestowed by our liberal media on any organization or group refusing to toe the politically correct line they trumpet. Nowhere on the American political scene are there any identifiable groups to be categorized as "left wing," who turn out to be merely "liberal."

Religious individuals and groups stirred to political action have quite appropriately raised the issue of "Family Values." Incredibly, the Clintons have attempted to steal that issue and now trumpet what is apparently their version of family values. This is an absolute absurdity in the hands of the morally degenerate Clintons, yet their alienation from any value system based on morals is so complete that they do not appreciate the absurdity. It is not possible for anyone who possesses a system of moral values to even consider supporting the Clintons or any others allowing themselves to be identified with them.

For starters, American physicians along with people of any moral persuasion have every reason to break all ties with anyone associated with the Clintons. West Virginia physicians in particular have reason to break all ties with the Democratic party.

– Stephen D. Ward, M.D.

In My Opinion

Medical care - A tale of four countries

The United States has the best health care system in the world -- PERIOD. It is the envy of medical professionals in all other countries. It is the medical mecca, the best place to be if you are seriously ill. Despite this, it is the subject of criticism based on indices such as infant mortality, life expectancy, etc., that really represent radically different lifestyles, manipulation of statistics, and ethnic differences rather than the strengths or weaknesses of the health care system.

President Clinton points out that we spend 14% of our gross national product on health care, compared to 9% in Germany and Japan. He says their health outcomes are equal or better than ours. Very well, let's look at Japan, Germany and Sweden.

JAPAN – Japan has the lowest infant mortality rate; the U.S. ranks 24th among 39 developed countries. The difference is in definitions. A "live birth" in the U.S. may be a stillbirth in Japan. Births between 20 and 27 weeks gestation are "live births" in the U.S., but stillbirths in Japan and many countries. Our infant mortality rate is 9.2 per 1,000 live births, less than 1%. For low birthweight infants, say those at 1,000 grams (2.2 lbs.) or less, the mortality rate may be 50%-80%. We try to save these infants with neonatal ICUs. Other countries dump them in the trashcan or incinerator as stillbirths. Is this what we want?

The Japanese doctor is paid $4 per established patient, $15 for a new patient. To make ends meet, he has to have high volume -- an average of 64 patients per day, less than five minutes each. Is this what we want? Patients receiving pelvic exams are lined up, several in the same room assembly line style. Is this what we want?

Japan has extremely high stomach cancer rates, very low rates of breast cancer, myocardial infarction, and hypertension, reflecting ethnic differences, not the health care system itself. Their deaths from cerebrovascular disease are twice the U.S. rate. In summary, there is no evidence we need to copy the Japanese model.

GERMANY – I lived in West Germany from 1967 to 1970 as a commanding officer serving in the 16th Medical Detachment in Crailsheim. The biggest complaint I heard from German doctors at the time was that the system allowed patients to receive six weeks at a health spa on regular prescription from their doctor. The German word "bad" means "bath." The towns of Bad Canstatt, Bad Mergentheim, Bad Tolz, Bad Wimpfen, etc., possess springs with allegedly curative properties. If you hurt anywhere below the nares, you could dangle your body in these waters at government expense. The benefit has been cut to two weeks, but is an example of health benefits prescribed by the political system.

The Germans have four to five times our automobile fatality rate. No mystery here; many parts of the autobahn have no speed limit. The cars and roads are built for speeds of 120-150 miles per hour and this is the rule, not the exception. You can be driving 130 miles per hour and be passed by a Porsche doing 150 miles per hour. As one German friend told me, "On the autobahn, there are no non-fatal accidents." A typical accident may cause $200,000 damage to vehicles, kill six to eight people, and the cost to the medical system is zero; no survivors. If this is what we want, we will have to redesign both roads and cars. In addition, the Germans have a higher mortality rate for myocardial infarction, twice the mortality rate for strokes, more than twice the rate for epilepsy, and three times the rate for prostate disease.

SWEDEN – Sweden was formerly the leader in infant mortality. Closer inspection of their figures, in addition to the comments already made about Japan, reveals several things. In the U.S., infant mortality is reported by hospitals. In Sweden, it is the parents' responsibility and they have five years to report a case of infant mortality -- with no penalty for non-reporting. If the aggrieved parents do not report it, or if they are unaware of the differences between a live birth, a stillbirth, an abortion, etc., who is hurt? -- the U.S., by having to compete with these figures.

In the U.S., the infant mortality is highest among blacks. It turns out that this is not a socioeconomic problem, but an ethnic one. College-educated, middle-class blacks have the same problem. If we excluded blacks, perhaps we would be number one. Preposterous, you say. The Swedes have no blacks, but they have Lapps, whom they exclude from their statistics. To the Swedes, the fact that the Lapps have resided in northern Sweden for two millennia does not make them Swedish. In the U.S., we include blacks, whites, orientals, native Americans, all comers.

Finally, research articles from Scandinavia talk about a 97%-98% patient follow-up. Since Sweden has a socialized system, missing a doctor's appointment is against the law. Miss one and you may attend the next in handcuffs. Miss two in a row and the police cannot find you. Regular prenatal checkups can reduce infant mortality, but we have never made the decision to have a police state enforce this, as Sweden does. Is this what we want?

The message here is clear. We have the best health care system in the world. The best always cost more, but may be well worth it. Critics of the U.S. system use phony statistics to cast the U.S. in a bad light -- exploiting differences in definitions, lifestyles, and ethnic characteristics -- not differences between medical care systems. The purveyors of these lies are not organizing planeloads of pregnant women to take them to Japan or Sweden for delivery. Any future actions at the federal level to totally revamp our system have the capability of destroying this premier position -- an act of political self-mutilation.

Wallace D. Johnson, M.D.
Beckley

Medical Assurance: By and for physicians

West Virginia physicians have a new partner. With the WVSMA's endorsement of Medical Assurance of West Virginia, Inc., West Virginia physicians finally can enjoy the protection offered by a West Virginia based, A+ (Superior) rated malpractice insurer. Physicians will have a committed, involved partner in Medical Assurance, and its parent company, Mutual Assurance, Inc., which has more than $500 million in assets and a long history of physician participation in its operations.

Mutual Assurance is one of the strongest physician-founded malpractice companies in America, and the story of the company's success explains a great deal of the excitement surrounding the partnership they seek to build with West Virginia's physicians. That story, in excerpts from a recollection written by the now deceased founding chairman, Dr. C. A. Lightcap, is as follows:

Mutual Assurance was forged in the fire of crisis.

The physicians on the Alabama Medical Association Insurance Committee thought we had worked out a durable insurance solution when Employers of Wausau agreed to cover Alabama physicians for five years. But in October 1975, severe losses forced Wausau to get out of the malpractice business. We were given until August 1977 to find another carrier.

We contacted 60 insurance companies, but received not one favorable reply. We turned to other state associations and heard horror stories, but found no solutions. Slowly at first, then with increasing speed, the concept of a doctor mutual company began to take shape.

Necessity, then, was Mutual Assurance's mother and we only assisted in the delivery; the baby would be born with or without us.

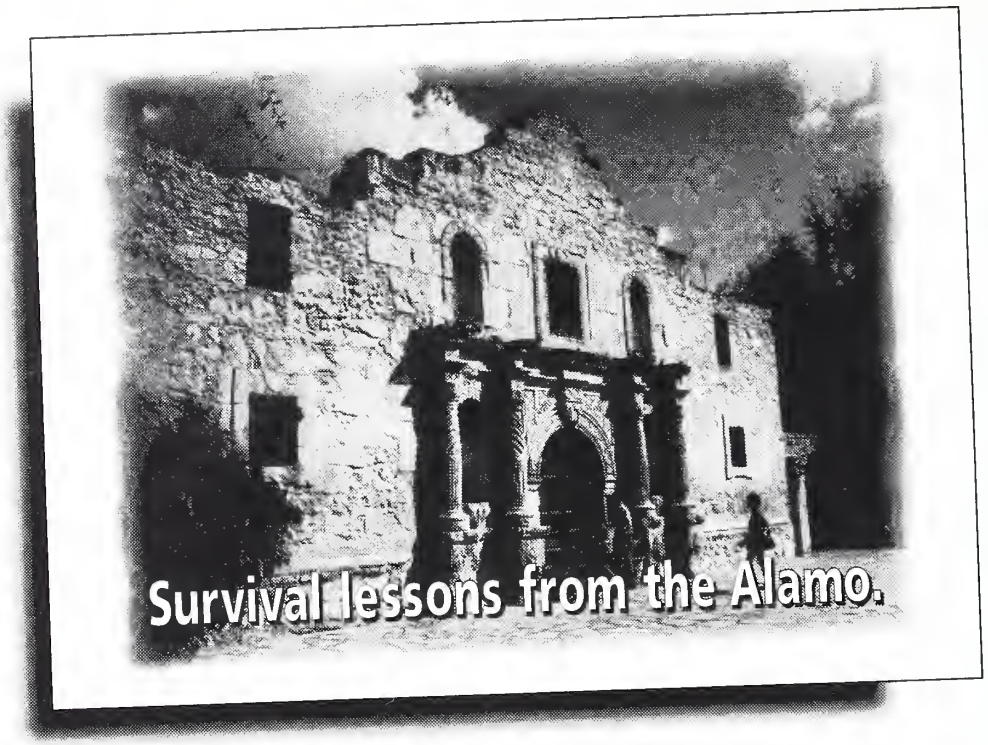
There were times when we wanted to quit -- we're physicians not underwriters -- but the malpractice climate did not give us the luxury of that choice.

Mutual Assurance was incorporated on October 1, 1976, and within seven months, more than 2,000 Alabama physicians enrolled. As the malpractice storm grew in intensity, Mutual Assurance and its policyholders weathered it through sound financial management and a commitment to defense.

Mutual Assurance began with physicians involved at every step and that tradition continues with physicians participating in the claims and underwriting process, and serving in the majority of seats on the MA Board of Directors. The company utilizes Regional Advisory Boards to stay in close touch with its policyholders and maintains a close liaison with its sponsoring medical associations.

Physician involvement is a key part of the foundation upon which Mutual Assurance has built its success, and West Virginia physicians will be called upon to be just as active in the operations of Medical Assurance. The WVSMA is excited about the commitment Mutual Assurance brings to West Virginia with Medical Assurance. The leadership of the WVSMA urges you to carefully evaluate the safety and security offered by Medical Assurance. You can rest assured that your interests will be well protected.

A. Derrill Crowe, M.D.
President
Medical Assurance of
West Virginia, Inc.



Interactions

Medical Staff Leadership Conference — January 13-15, San Antonio, Texas

Health system reform might seem like a never-ending battle, but with leadership, vision, and perseverance, you and your medical staff can overcome any obstacle. Learn what it takes to succeed in today's rapidly changing environment. Come to *Interactions* in beautiful San Antonio, Texas, January 13-15.

Experience a new way of thinking about the future.

This year's conference, "Physician Empowerment and Teamwork in a Changing Environment," will help you experience a change of perspective on the 21st Century.

Learn how to manage change.

During *Interactions*, we will address emerging trends in health care delivery and how best to manage them. Among the trends we will discuss are:

- Physician/hospital relationships
- Economic competition
- Physician autonomy
- Resource allocation
- Regulatory constraints

Gain new leadership skills.

Special emphasis will also be placed on developing and refining your strategic planning, team building, and communication skills. Each participant will learn how to be a more effective arbitrator, facilitator, manager, negotiator, problem solver, and peacemaker.

Your team leaders.

Sponsored by the *American Medical Association,* in cooperation with the *National Association Medical Staff Services* and the *Texas Medical Association*, this conference features well known experts from the health care field.

Who should attend.

The curriculum is designed to benefit experienced and newly elected or appointed medical staff leaders, including: chiefs of staff, department chairs, vice presidents of medical affairs, medical staff committee chairs, and medical staff services professionals.* Bring a team from your hospital!

For more information or to register, call **800 621-8335.**

* The AMA designates the *Interactions* conference for 18 credit hours of Category 1 of the Physician's Recognition Award of the AMA.

American Medical Association
Physicians dedicated to the health of America

BALTIMORE

SUCCESSFUL MONEY MANAGEMENT

You're Invited!!!

We are pleased to announce the 1994 Successful Money Management Seminar schedule. In three exciting sessions, the workshop introduces you to key concepts and practices of wise money management. You'll learn how to minimize your taxes, maximize your investment returns, and provide a secure future for yourself and your family.

Another Member Benefit From Your Association!

Areas of Discussion!

- **1993 Tax Law Overview**
  - Summary of the new Tax Law
  - New Opportunities in tax planning
- **Estate Planning**
  - The probate process
  - Wills, Trusts, Estate Taxes
- **Equity/Fixed Income Investments**
  - Stocks, Bonds, Ltd Partnerships
  - Purchasing strategies, Asset allocation
- **Retirement Planning**
  - Qualified Pensions (SEP's, 401K, 403B)
  - Select Benefit Plans

Registration Fee $250.00
Spouse Fee $125.00

Spouse's fee waived if registered 10 days before start of seminar.

If you would like to have a special seminar done in your area, notify the Medical Association. We will be happy to accommodate you.

Seminars Consist of Three Sessions
6:00 PM - 9:30 PM
Lite Meal Served

Beckley Area
Wednesday
October 26th

Charleston Area
Wednesdays
November 2nd, 9th & 16th

Fayette County
Thursdays
December 1st, 8th & 15th

✓

- ❑ **Beckley Area** October 1994
- ❑ **Charleston Area** November 1994
- ❑ **Fayette County** December 1994

Reserve Your Place!

Don't Wait!!!

Remember, spousal fee is waived if reservations are confirmed 10 days prior to the seminar date.
Return this self-addressed card, or call the WVSMA at (304) 925-0342.

Please Call Today!!!

Name _____

Spouse's Name If Attending _____

Address _____

City _____ State _____ Zip _____

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At Mid-Winter

Entertainment to include performance by Dr. Neri, karaoke sing along, dance music

By popular demand, Dr. Florencio "Jun" Neri will again present a special musical variety show at this year's WVSMA Mid-Winter Clinical Conference on Saturday evening, January 21 at the Radisson Hotel in Huntington. In addition to the concert and slide show which Dr. Neri has planned, Dr. Rano Bofill of Man will again have his laser karaoke machine available so guests can perform their favorite songs.

Dr. Neri, a general practice physician in Princeton, is a native of the Philippines who is well known by his colleagues for his singing abilities. He has performed at many state and county medical meetings, as well as at weddings, benefit concerts and other local events. Dr. Neri is currently the president of the Philippine Medical Association of West Virginia.

Dr. Bofill, who is also a native of the Philippines, is a radiologist for Roane General Hospital in Spencer. He and his family reside in Man, where he has been singing since 1985 at nursing homes and medical meetings. A couple of years ago, he purchased a laser karaoke machine which he has been transporting with him to a variety of events. He recently took his "sing along show" on the road to Boston for the annual meeting of the Filipino American Association of Family Physicians, and to Richmond for the annual meeting of the Virginia Association of Filipino Physicians.

Dr. Jun Neri performs a song by Elvis Presley at last year's WVSMA Mid-Winter Clinical Conference.

Dr. Rano Bofill will again be bringing his laser karaoke show for meeting participants.

"I am very pleased to again be able to offer the karaoke show to the members and guests attending the WVSMA's Mid-Winter Conference," Dr. Bofill said. "In the past year I have added many new discs to my collection, so I now have Spanish and gospel recordings available as well as rock 'n' roll, country, popular, and children's music. I will be offering trophies for the best solo, best duet and best group performances. In addition, I will play a wide variety of dance music, such as the limbo, tango and electric slide during the breaks in the singing," he added.

This special evening of entertainment is being presented in conjunction with a reception by Acordia of West Virginia and Medical Assurance of West Virginia, Inc. The reception will begin at 7 p.m., and then Dr. Neri will perform at 8 p.m., followed by Dr. Bofill's karaoke show.

State awarded grant for tobacco prevention program

West Virginia is one of nine states recently awarded a $1 million grant from the Robert Wood Johnson Foundation to implement a SmokeLess States Program, which is aimed at reducing and preventing tobacco use among youth.

The grant was awarded to the West Virginia Hospital Association's educational affiliate, the West Virginia Hospital Research and Education Foundation (WVHREF). Implementation of the Smokeless States Program will be coordinated through the West Virginia Tobacco Control Coalition, an advisory group to the Bureau of Public Health.

Funding for the four-year project began in August. The program initiatives are a result of a collaborative effort between the WVHREF, the Bureau, the American Lung Association of WV, Inc., the West Virginia State Medical Association, the Mary Babb Randolph Cancer Center and the Coalition.

Program goals include reducing the number of children and youth who begin using tobacco products and reducing the number of West Virginians who continue to smoke or use smokeless tobacco. Other plans will include initiatives to increase public awareness that reducing tobacco use is an important component to health care reform through encouraging healthy lifestyle costs associated with chronic illnesses.

For more information on this new program, contact project director Sharon Lansdale at (304) 347-6605.

Foundation issues call for proposals to aid underserved

A call for proposals for a second round of planning grants for the $14 million REACH OUT program was announced recently by the Robert Wood Johnson Foundation. REACH OUT is a major national effort to mobilize private physicians to improve access to care for medically underserved Americans.

In August, planning grants were awarded to 22 private physicians' groups in 21 communities throughout the U.S. to develop new approaches for delivering medical care to people who currently have difficulty obtaining it. Those grantees received development awards up to $100,000, and based on progress made during the first year, they will then be eligible to receive three-year implementation grants averaging $200,000.

The second round will include up to 28 additional physician-initiated partnerships. A workshop for interested applicants will be held on January 20, with an application deadline of March 14. Recipients of the second round of planning grants will be announced on August 1.

REACH OUT is looking for innovative models where private physicians provide leadership to meet the needs of people who currently have difficulty obtaining health care. In addition, as health insurance is expanded through state and federal reforms, there is a corresponding need to organize care for those who are newly covered.

Potential applicants should contact the REACH OUT National Program Office at 401-453-5120.

Forum to analyze state's laws concerning incapacitated patients

"The Ethics and Law in West Virginia of Health Care Decision Making for Incapacitated Patients" is the subject of the West Virginia Network of Ethics Committees' next forum on January 27 at the Days Inn in Flatwoods. This meeting is designed to help West Virginia health care professionals apply the statutes outlined in the Medical Power of Attorney Act, the Revised Natural Death Act, the Health Care Surrogate Act of 1993, and the Do Not Resuscitate Act.

Registration for the meeting will begin at 9:30 a.m., and then Patrick Kelly, J.D., an attorney with Steptoe and Johnson in Charleston, will present a legal overview of these four statutes. Following Kelly's presentation, Dr. Alvin Moss, director of the Center for Health Ethics and Law at the Robert C. Byrd Health Sciences Center of WVU in Morgantown, will discuss medical and ethical issues pertaining to these laws. The morning session will then conclude with a lecture on the government's perspective of these acts of legislation by Charles Conroy Jr., director of the Office of Geriatrics and Long Term Care of the State Department of Health and Human Resources.

After a break for lunch, a number of cases will be presented to challenge participants' abilities to apply these laws to unique situations. A wide variety of questions will be answered.

For more details, phone the West Virginia Network of Ethics and Law at (304) 293-7618.

Ophthalmology Academy schedules 48th spring meeting

The West Virginia Academy of Ophthalmology's 48th Annual National Spring Meeting will be held April 27-30 at The Greenbrier in White Sulphur Springs.

Featured speakers for this year's meeting and their subjects include John Linberg, M.D., plastic surgery; Brooks McCuen II, M.D., retina; Philip Shelton, M.D., J.D., managed care and cataracts; and Thom J. Zimmerman, M.D., Ph.D., glaucoma. The West Virginia Academy of Ophthalmology has designated this CME program for 12 credit hours of Category 1 of the AMA's Physician's Recognition Award.

For further information, contact Pam Stevens, conference coordinator, West Virginia Academy of Ophthalmology, P.O. Box 5008, Charleston, WV 25361, (304) 343-5842 or (304) 344-8466.

Regional Hospice conference to be held in Charleston at UC

"Hospice and Palliative Care" is the title of a regional conference which will be presented at the University of Charleston on November 2 and 3. This multidisciplinary program is sponsored by Kanawha Hospice Care in cooperation with CAMC, and will focus on the special needs of terminally-ill patients and their families.

Topics include pain and symptom management, psychosocial interventions, family dynamics, communication skills and spirituality. A total of 12.5 CME credits in the AMA's Category 1 will be offered to participants attending both days. Continuing education credits will also be provided to nurses, social workers and counselors.

For further details, call 768-8523 or 1-800-560-8523.

Snowshoe site for cardiology meeting

The American College of Cardiology will present this year's "Cardiovascular Conference at Snowshoe" from February 6-8 at the Mountain Lodge Conference Center in Snowshoe.

A total of 14.5 CME credits in the AMA's Category 1 will be offered.

For information contact: Registration Secretary, Extramural Programs Dept., American College of Cardiology, 9111 Old Georgetown Rd., Bethesda, MD 20814-1699; (800) 257-4739 (outside the U.S. and Canada, (301) 897-2695).

NIH issues consensus report about treating ovarian cancer

A National Institutes of Health (NIH) consensus development statement entitled *"Ovarian Cancer: Screening, Treatment and Follow-up"* is now available from the NIH Office of Medical Applications of Research (OMAR).

For a free, single copy, contact William Hall at (301) 496-1143.

APA offering free booklet on depression

The American Psychiatric Association has published a pamphlet on depression which is free to the public. Anyone interested in receiving a copy may write to the American Psychiatric Association, DPA/Dept. NB, 1400 K Street, NW, Washington, DC 20005.

Clinical depression is one of the most common and treatable mental illnesses with over 10 million Americans suffering from it in any six-month period. Symptoms may include a noticeable change of appetite, change in sleeping patterns, loss of interest in previously enjoyable activities, loss of energy, inability to concentrate, and recurring thoughts of death or suicide that last for at least two weeks.

Continuing Medical Education

Listed on this page are some of the upcoming CME programs which will be held in the state. Unless otherwise noted, the events are presented at the location under which they appear.

If you would like to have the CME programs offered by your institution or association for physicians printed in the *Journal* or obtain more details about the meetings listed, please contact Nancy Hill, managing editor, at 925-0342.

Marshall University - Huntington

November 11-13
"8th Annual Family Practice Weekend and Sports Medicine Conference" (sponsored by the WV Chapter of the American Academy of Family Physicians, the Family Medicine Foundation of WV, the MU Dept. of Family and Community Health, and Jose Ricard, M.D.), Radisson Hotel, Huntington

Robert C. Byrd Health Sciences Center of WVU - Charleston

October 22
"Laser Surgery Seminar XI" (sponsored by The Eye and Ear Clinic of Charleston; the Dept. of Surgery at the Robert C. Byrd HSC of WVU, Charleston Division; and CAMC), Charleston Marriott

November 3
(Teleconference) "Role of Childbirth Education: Teaching Women Active Birth"

November 17
(Teleconference) "Evaluation of the Worker's Compensation Patient: IME and Functional Capacity Examinations"

Robert C. Byrd Health Sciences Center of WVU - Morgantown

October 22
"Current Topics in Emergency Medicine" (sponsored by the WVU Dept. of Emergency Medicine), Robert C. Byrd HSC, Morgantown*

October 27-30
"The First International Conference on Prevention" (sponsored by The Council of Geriatric Cardiology, The Center for the Study of Aging, The Lawrence Frankel Foundation, the Robert C. Byrd Health Sciences Center of WVU, three medical schools of West Virginia, and Senator Jay Rockefeller), Charleston Civic Center, Charleston

October 28
"Fall Cancer Conference Breast Cancer: The Newly Diagnosed Patient" (sponsored by the WVU Dept. of Medicine, Section of Hematology/Oncology and the MBRCC), Robert C. Byrd HSC, Morgantown*

October 28-29
"Third Annual Appalachian Regional Stroke Symposium" (sponsored by the WVU Office of CME and MountainView Regional Rehabilitation Hospital) MountainView Reg. Rehab. Hospital, Morgantown*

November 4-6
"The Rural Health Conference" (sponsored by WVU Office of CME and the Office of Rural Health Policy), Lakeview Resort and Conference Center, Morgantown

November 11-13
"The Art in the Science of Healing – The 11th Annual Hypnosis Workshop" (sponsored by the WVU Dept. of Behavioral Medicine/Psychology and the Carruth Center for Counseling and Psychological Services), Robert C. Byrd HSC, Morgantown

November 17
(MDTV) "Evaluation of Breast Lumps," Rick Hostetter, M.D. (Participants must pre-register at their MDTV site)

November 18-19
"OB/GYN Women's Health Symposium 1994" (sponsored by the WVU Dept. of OB/GYN), Robert C. Byrd HSC, Morgantown*

November 19
"David Zackquill Morgan, M.D. Sixth Annual Senior Care Conference" (sponsored by the WVU Geriatric Program), Robert C. Byrd HSC, Morgantown*

** Held in conjunction with a WVU football game*

Outreach Programs

Key to Sponsors

★ *Robert C. Byrd Health Sciences Center of WVU, Morgantown*

☐ *CAMC/Robert C. Byrd Health Sciences Center of WVU, Charleston*

Fairmont ★ Fairmont General Hospital, Nov. 1, 7:30 p.m. "Work Hardening, Disability Rating, Return to Work Criteria," Janie Vale, M.D., M.S.P.H.

Gassaway ☐ Braxton County Memorial Hospital, Oct. 26, 6:30 p.m., "Clot Buster Update," Harold Selinger, M.D.

Martinsburg ★ VA Medical Center, Nov. 3, 3 p.m., "Ultrasound Update," Vickie Williams, M.D.

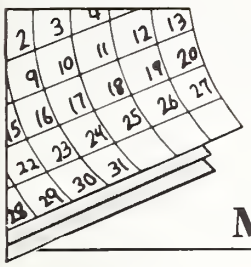
New Martinsville ★ Wetzel County Hospital, Nov. 10, noon, "Alzheimer's Disease," Robert Keefover, M.D.

Oak Hill ☐ Plateau Medical Center, Oct. 25, 6:30 p.m., "Lumbar," Constantino Amores, M.D.

Parkersburg ☐ Camden Clark Hospital, Nov. 16, noon, "Preplacement Evaluation," John Coumbis, M.D., M.S.P.H.

White Sulphur Springs ★
The Greenbrier Clinic, Oct. 24, 4 p.m., "Office Practice of Sports Medicine," William Post, M.D.

The Greenbrier Clinic, Nov. 28, 4 p.m., "Disability Rating: Contemporary Issues in West Virginia Practice," Janie Vale, M.D., M.S.P.H.



Medical Meetings

October

27-30–The First International Conference on Prevention (sponsored by the World Health Organization, The Council of Geriatric Cardiology, The Center for the Study of Aging, The Lawrence Frankel Foundation, the Robert C. Byrd Health Sciences Center of WVU, the three medical colleges of West Virginia, and Senator Jay Rockefeller), Charleston

28-29–Healthcare Quality Management: Review and Study Session (sponsored by the National Association for Healthcare Quality), Atlanta

28-29–Clinical Innovations in Ob/Gyn Ultrasound (sponsored by the American Institute of Ultrasound in Medicine), New York

November

1-4–American Academy of Neurological Surgery, Sea Island, Ga.

2-6–88th Annual Scientific Assembly of the Southern Medical Association, Orlando, Fla.

5-9–American College of Allergy and Immunology, San Francisco

10-13–Annual Scientific Meeting of the American Pain Society, Miami Beach, Fla.

11–Fifth Annual Rush Symposium on Hepatic and Biliary Disease and Liver Transplantation, Chicago

11-13–8th Annual Family Practice Weekend and Sports Medicine (sponsored by the WV Chapter of the American Academy of Family Physicians and the Family Medicine Foundation), Huntington

12-17–American Association of Blood Banks, San Diego

13-16–29th World Biennial Meeting of the International College of Surgeons, London

17-20–Consultation-Liaison Psychiatry: The Bridge to Primary Care, Phoenix

18-20–2nd Clinical Conference on Women's Health in the Pathways to Change (sponsored by the Association of Reproductive Health Professionals), Kansas City, Mo.

30–Physician-Based Information Systems: Planning and Selecting Computer Systems and Software (sponsored by the Medical Records Institute), Washington, D.C.

December

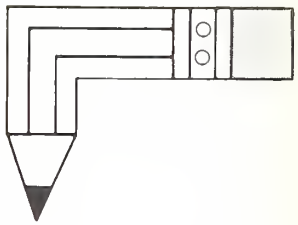
1–Preparing for Electronic Patient Record Systems (sponsored by the Medical Records Institute), Washington, D.C.

2–Implementing and Managing a Health Care Information Security Program (sponsored by Medical Records Institute), Washington, D.C.

For More Information . . .

Contact the Journal at (304) 925-0342.

Poetry Corner



Remembrance

Looking back along the way
he traveled through his life
and come what may
to check the depth of strife.

I remember the precept given
by that oak physician Sleeth
and follow a path once driven
in the face of grief.

The patient and the child
reflect -primo non nocere-
unlike a fancy mild
a chart of -docere-.

In a mandarin scheme
he held up the light
and etched out his theme
to put up the good fight.

John Henry McWhorter, M.D., M.P.H.

Please address your submissions for Poetry Corner to Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

"THIS SHOULD HELP, BUT DON'T OPERATE ANY HEAVY MACHINERY."

Department of Health & Human Resources

Bureau of Public Health News

This page of material is submitted and paid for by the Bureau of Public Health.

EMS sytem undergoing changes

West Virginia's emergency medical services (EMS) system is undergoing a number of changes, including the addition of a new medical director for the program and the consolidation of area offices that coordinate EMS activities.

Through its Office of Emergency Medical Services (OEMS), the Bureau of Public Health oversees all statewide EMS activities such as training and certification for EMTs and paramedics, funding for ambulances and life support equipment, enforcement of standards and policies, and coordination of the EMS communications system. In addition, OEMS also provides public education on safety and injury prevention.

John E. Prescott, M.D., F.A.C.E.P., has been named medical director for the OEMS, replacing Frederick M. Cooley, M.D., who retired in June. Dr. Prescott, who is also an associate professor and chairman of the Department of Emergency Medicine at the Robert C. Byrd Health Sciences Center of WVU, will be working with the OEMS to provide technical assistance and consultation to EMS agencies in the state, medical oversight and direction to the OEMS, and assistance to the EMS system in times of disaster or emergencies.

This spring, a legislative committee directed the Bureau of Public Health to streamline the EMS system so that it could be run more efficiently and effectively. The decision was made to contract with only one area office, rather than the two offices that had been utilized to serve as liaisons with regional EMS offices throughout the state. After a state review process, the Southern Emergency Medical Services, Inc. (SEMS) was awarded a grant to provide statewide EMS services.

A search is also underway for an administrative director for the OEMS. For more details on the state's EMS programs, call Acting Director Chris Gordon at (304) 558-3956.

Enrollment in VFC program urged

The Bureau of Public Health's Immunization Program staff invites members of the private medical community to enroll in the national Vaccine for Children (VFC) Program which began October 1. The program provides enrolled providers with vaccine for eligible children at no cost.

Currently, parents who can't afford the full series of immunizations are referred to public health clinics, but many county health departments have limited resources to meet the demand for immunization services. With the VFC Program, parents of eligible children will have the option of having children vaccinated at a public health clinic or by a VFC-enrolled private health care provider. Providers should enroll in the program now to receive their first free shipment of vaccine as soon as possible.

The VFC Program was created as part of the nation's Childhood Immunization Initiative to provide private providers relief from the high costs of vaccine for needy children. The national program can contribute approximately $272 for every eligible child, so West Virginia children receive the recommended vaccinations on time.

Children ages 18 and under are eligible for the program if they meet one or more of the following conditions:

* They are enrolled in Medicaid
* They have no health insurance
* They are an American Indian or Alaska native
* They have health insurance that does not cover vaccinations (these children would be served by a federally qualified health center.)

The state and national goal is to raise the percentage of properly immunized two-year-old children to 90% by the year 1996. Currently, just over half of the state's two-year-olds are up-to-date on vaccinations.

For more details about the Vaccine for Children Program, call the Bureau's Immunization Program at (304) 558-2971 or 1-800-642-3634.

Chlamydia screenings offered

The Bureau of Public Health is joining forces with agencies in several other mid-Atlantic states in an effort to control the spread of chlamydia, a common sexually transmitted disease (STD). Public health officials expect the Chlamydia Project to prevent as many as 1,300 infections among West Virginians alone each year, as well as serve as a model for a nationwide chlamydia prevention effort. The project is administered through the Bureau's STD Program, in conjunction with its Family Planning Program and its Office of Laboratory Services.

In September, all 181 public health STD and family planning clinic sites in West Virginia began providing the Chlamydia Project services to women and their partners. These services include:

* free chlamydia testing to 40,000 women in STD and family planning clinics each year;
* medical treatment and counseling for those women who test positive for chlamydia and for their partner; and
* community outreach to raise public awareness of chlamydia and the availability of the screening services.

Chlamydia is second only to the common cold as the most prevalent infectious disease in the world. State health officials are projecting that this new project can help prevent an additional 1,080 cases of pelvic inflammatory disease, 33 cases of ectopic pregnancy, and 187 cases of infertility in West Virginia each year. This would result in an estimated annual savings of $1 million in health care costs.

For more details, call Robert Johnson Sr., director of the Bureau's STD Program, at (304) 558-2950 or 1-800-642-8244.

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

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Indications: Yocon® is indicated as a sympathicolytic and mydriatic. It may have activity as an aphrodisiac.

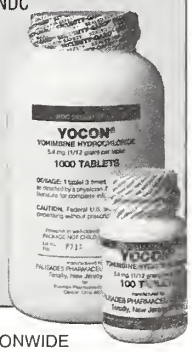
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



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1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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ROBERT C. BYRD HEALTH SCIENCES CENTER
OF WEST VIRGINIA UNIVERSITY

Compiled from material furnished by the Robert C. Byrd Health Sciences Center of West Virginia University, Communications Division, Morgantown

Prescott appointed state EMS director

Prescott

Dr. John Prescott, associate professor and chair of emergency medicine, has been appointed state EMS director by the West Virginia Office of Emergency Medical Services.

In this position, Dr. Prescott will provide assistance and consultation to all state EMS agencies on a part-time basis. He will also provide medical direction to the OEMS and assist the EMS system during disasters and emergencies.

Ducatman elected trustee for ABPM

Ducatman

Dr. Alan Ducatman, a professor and director of the Institute of Occupational and Environmental Health, was recently elected a trustee of the American Board of Preventive Medicine.

The ABPM accredits physicians with public health training in preventive, occupational or aerospace medicine.

Murray appointed to Halsted Society board

Dr. Gordon Murray, professor and chair of surgery, has been named to the board of directors of the Halsted Society.

Dr. Murray's two-year appointment was announced at the society's recent meeting in Ann Arbor, Mich.

Stauber speaks at cranio-mandibular meeting, named fellow

Stauber

William Stauber, Ph.D., professor of physiology and neurology, delivered a lecture at the annual meeting of the International College of Cranio-mandibular Orthopedics on the physiological basis for TENS and non-traditional approaches to the treatment of cranio-mandibular dysfunction.

More than 125 dentists who specialize in temporomandibular dysfunction, attended the program as part of the Eighth Bernard Jankelson Memorial Lecture Forum. At the meeting, Dr. Stauber was also named an honorary fellow of the the International College of Cranio-mandibular Orthopedics.

Rosenbluth named Scholar-in-Residence

Rosenbluth

Sidney Rosenbluth, Ph.D., dean of the School of Pharmacy, has been named a Scholar-in-Residence with the American Association of Colleges of Pharmacy (AACP).

"For the next 10 months, I will work and study at the AACP's headquarters in Alexandria, Va.," Dr. Rosenbluth said. "I will study aspects of wellness from a pharmacist's point of view."

Dr. Rosenbluth recently completed a term as chair of the AACP's Council of Deans. He has resigned as dean, but will return to the School of Pharmacy in July 1955 for a full-time faculty post. James Shumway, Ph.D., associate dean for educational programs in the School of Medicine, will serve as interim dean while a search for a new dean is underway.

Ma appointed interim assistant dean of School of Pharmacy

Joseph Ma, Ph.D., has been named interim assistant dean for research and graduate programs in the School of Pharmacy.

Dr. Ma, professor of pharmaceutics and pharmaceutical chemistry, joined the School of Pharmacy in 1976. He earned his doctoral degree in physical chemistry from Duquesne University and completed a postdoctural fellowship in pharmaceutics at the University of Georgia College of Pharmacy.

Azzaro named to post at Florida college

Albert J. Azzaro, Ph.D., professor of pharmacology/toxicology, neurology and behavioral medicine/psychology in the School of Medicine, has been named chair of pharmacology at the Florida College of Osteopathic Medicine in Tarpon Springs, Fla.

Dr. Azzaro has been a member of the WVU faculty for 23 years. He was director of the Chestnut Ridge Hospital Clinical Pharmacology Laboratory for Psychotropic Drug Analysis.

Fine needle aspiration conference planned

On April 29, the West Virginia Bureau of Public Health's Breast and Cervical Cancer Screening Program (BCCSP) is sponsoring a CME conference entitled "*Fine Needle Aspiration for Primary Care*" with the WVU School of Medicine Department of Pathology, the Office of CME, the West Virginia Association for Pathologists, and the West Virginia Cytology Society.

This CME workshop will be held at the Robert C. Byrd Health Sciences Center in Morgantown, and is open to pathologists, cytotechnologists, general practitioners and nurses. Didactic and hands-on sessions concerning clinical topics and cytology will be presented.

For more details, contact Patricia Hilton Wilbur at 293-2370.

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Marshall University School of Medicine

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington

MU Med School ranks 2nd in U.S. in number of grads entering FP

The Marshall University School of Medicine ranked second in the nation last year in the percentage of graduates entering family practice residencies, according to a study reported in the September issue of *Family Medicine.*

The study, prepared by the American Academy of Family Physicians, showed that 32.7 percent of MU's medical grads entered family practice residencies in 1993. Only the Mercer University School of Medicine ranked higher. MU also retained its No. 3 ranking in the three-year averages, with 27.7 percent of graduates entering family practice between 1991 and 1993. The study included one- and three-year data from every U.S. medical school, and one-year data from osteopathic schools.

Dr. Robert B. Walker, chairman of the Department of Family and Community Health at Marshall, said several factors contribute to the school's consistently good outcomes in producing primary care physicians.

"We believe that our admissions policies, our structure as a community-oriented medical school, and strong role models in primary care and rural practice all play major roles," he said. "Certainly these results reflect Marshall's overall mission, which we are gratified to see in our students' choice of careers."

Nationally, 12.3 percent of 1993 graduates entered FP residencies, the highest percentage in a decade.

Students celebrate Primary Care Day

Marshall medical students celebrated the first National Primary Care Day with a six-day series of lunchtime programs from practitioners.

In addition to faculty members representing each of Marshall's generalist departments, the series featured Dr. Carroll Christiansen of Summersville and Dr. Ron Stollings of Madison. A follow-up event was scheduled for early October to allow first- and second-year medical students to meet with Marshall students who are participating in the Rural Physician Associate Program, the Kellogg Program, the Rural Health Initiative and Marshall's accelerated residency program in family practice.

"We hoped to give first- and second-year students a better understanding of what a day in the life of a primary care physician consists of," said Brian Brautigan, the president of the fourth-year class who chaired the planning task force. "We wanted to promote not just primary care in general, but rural primary care specifically. "We felt that connecting students directly with practicing physicians would help them make more informed decisions about the disciplines they want to go into, and it also allowed them to become familiar with the physicians at two rural sites where they can do electives later," he added.

The concept of National Primary Care Day originated from medical students themselves. This first event was sponsored by nine national groups of med students and the Association of American Medical College's Office of Generalist Physician Programs, and students from at least 135 of the nation's 142 med schools planned observances.

Biotechnology expert consults with MU, business leaders

Dr. Michael Pappas, scientist-author of *The BioBusiness Handbook*, met recently with MU and community leaders to consider the potential for developing biotechnology industry in Huntington.

According to Dr. L. Howard Aulick, assistant dean for research development for the MU School of Medicine, a Center for Applied Biotechnology would build on campus-based expertise and help establish successful private businesses in the fields of forensic, medical and environmental science.

"We have several groups of Marshall researchers who are interested in developing projects through a biobusiness channel," said Dr. Aulick. "As we have talked to people in the community, we also have found individuals interested in the economic development possibilities and even potential investors. "We discussed our business plans with Dr. Pappas so that he can evaluate them and advise us on the best way to proceed," he added.

Dr. Pappas' schedule included meetings with the Huntington Area Development Corporation (HADCO), executives of the Marshall Research and Economic Development Center, and members of the Center for Applied Biotechnology Team, which includes representatives of Marshall's College of Business, School of Medicine, and Center of Environmental, Geotechnical and Applied Sciences.

MU plans to bring in several other biotechnology experts in the coming months. "We believe Huntington has the potential to create a highly successful biotechnology industrial park," Dr. Aulick said.

Dr. Pappas is director of analytical chemistry and immunochemistry for Advanced Instruments Inc. in Norwood, Mass., and has operated a biotechnology consulting company since 1989. His credentials also include two U.S. patents for diagnostic procedures; proposal and manuscript review services for many professional organizations, and nine research grants and contracts from federal, state and private sources.

Medical alumni induct Bateman, Collins

Marshall medical alumni recently named Dr. Mildred Mitchell-Bateman and Paul H. Collins honorary members of their Alumni Association.

Dr. Bateman, an active faculty member who was founding chair of MU's Department of Psychiatry, was formerly director of the West Virginia Department of Mental Health. Mr. Collins played a key administrative role in the school's development, and served as associate dean for administration until he retirement in 1981.

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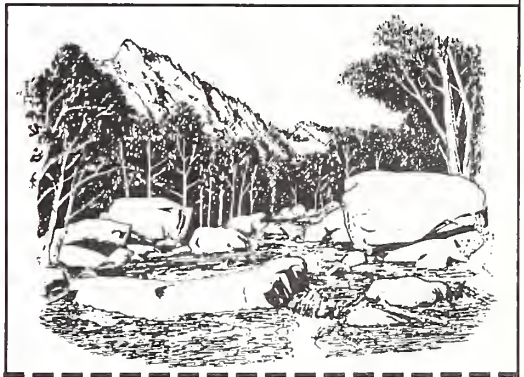

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Alliance News

Working in Alliance with you and the WVSMA!

The name of the organization I represent is the West Virginia State Medical Association Alliance. The WEST VIRGINIA STATE MEDICAL ASSOCIATION - - **YOUR** - - ALLIANCE. I believe we truly live up to that title because we really strive to work in ALLIANCE with you and your organization!

We work in support of:

*your profession and its perception by the public;

*the legislative issues that affect your profession, medicine, as well as the health of the public;

*health issues that are of concern to you; and

*fund raising for medical education and research.

Is your spouse a member of West Virginia State Medical Association Alliance? Chances are, your answer is NO because only 26% of the spouses of WVSMA members are members of the Alliance! If you truly believe that the Alliance is supportive of the West Virginia State Medical Association, you should make sure your spouse belongs to the Alliance this year.

I know, I know! Many of them are busy with their own interests. While we could certainly use their willing "hands" to help with our work for you, we need their financial support (through their dues) even more! I don't have to tell you, money is very important to accomplish things in this world. So, I urge you to get your spouses to pay their dues and join the Alliance. Or better yet, you pay their dues for them!

The project I have chosen for this year is "*Combating the Negative Effects of Media on Children and Youth.*" Five actions of the 1994 AMA House of Delegates addressed components of this issue. It comes as no surprise to anyone who has spent even a small amount of time around children that they imitate what they see and hear. Think of the 18-month-old who hears an exasperated parent let loose an expletive - - more than likely, that child will repeat that word! Multiply that by all the profane words children hear during their years of exposure to TV, movies and radio, and it's no wonder today's young people use so much foul language!

Now, think of all the promiscuous sex that is modeled in our media. Each year the typical teen sees 14,000 sexual encounters JUST ON TV! Is it any wonder:

*that 52% of females ages 15-19 and 75% of 18-year-old males admit to experiencing premarital sex;

*that unmarried teen births had risen to 69% by 1991 despite the fact that abortions end 42% of all pregnancies to women under age 20; and

*that 1 in 8 teens in the U.S. acquires a sexually transmitted disease each year while the risk worldwide is 1 in 20.

Now let's look at violence. More than 3,000 studies by independent researchers consistently show that repetitive viewing of violence:

*provokes imitative behavior in children;

*removes inhibitions on aggression;

*desensitizes children to violence so that they accept it as normal and natural; and

*can create exaggerated fears, especially in young children, about how dangerous the world really is.

The average child sees more that 40,000 murders and 200,000 rapes, stabbings, assaults, car wrecks and screaming victims on TV alone by the time he turns 18. Is it any wonder teen violence is so rampant and carries into adulthood? The yearly death toll due to handguns is 10 times higher than the death toll at the peak of the polio epidemic in the 50s!

WHO'S PROTECTING OUR CHILDREN? The future of today's children is in our hands! What will we do with it?

Your Alliance has printed a brochure addressing this issue as well as actions to take in combating the problem. This brochure is available, free of charge, and appropriate for distribution to the public. If you would be willing to make these available through your office or an organization you belong to, please contact a member of your local Alliance or the WVSMA office to get a supply.

I look forward to serving on your Council and working in Alliance with you and your organization in the coming year. Thank you for the support you give the WVSMAA.

Sue Bryant
WVSMAA President

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***Teen Suicides**
***Tobacco Use**
***Violence**
***Rape**

Your $43 dues entitle you to both WVSMAA and AMAA memberships

Contact: Linda Elliott, WVSMA President Elect
6 Holly Road
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242-5922

Annual Audit 1993

The annual audit of the West Virginia State Medical Association for the calendar year 1993 has been completed by Ernst & Young of Charleston. The complete audited financial statements including the report of independent auditors is as follows:

REPORT OF INDEPENDENT AUDITORS

To the Council
West Virginia State Medical Association

We have audited the accompanying balance sheets of West Virginia State Medical Association (the Association) as of December 31, 1993 and 1992, and the related statements of revenues and expenses—unrestricted fund, changes in fund balances, and cash flows—unrestricted fund for the years then ended. These financial statements are the responsibility of the Association's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of West Virginia State Medical Association at December 31, 1993 and 1992, and the results of its operations and its cash flows for the years then ended in conformity with generally accepted accounting principles.

Ernst & Young

March 30, 1994

BALANCE SHEETS–WVSMA

UNRESTRICTED FUND	December 31 1993	1992
ASSETS		
Cash and cash equivalents—Note 4	$ **908,628**	$ 721,859
Investments, at cost (market value $203,125 as of December 31, 1992)—Note 1	**—**	200,035
Accounts receivable	**63,802**	35,971
Other assets	**14,734**	16,719
Land, building, and equipment, net—Note 2	**623,455**	641,360
	$1,610,619	$1,615,944
LIABILITIES		
Dues collected in advance	$ **496,926**	$ 552,758
Other deferred revenue	**57,262**	750
Medical scholarship obligation	**9,163**	13,663
Accounts payable	**59,580**	28,556
Accrued income taxes payable	**8,000**	7,706
Accrued expenses and other liabilities	**15,353**	32,486
Note payable to bank—Note 4	**492,185**	502,616
	1,138,469	1,138,535
FUND BALANCE		
Undesignated	**472,150**	477,409
	$1,610,619	$1,615,944
Restricted Fund—Note 1		
ASSET		
Investment in common stock	$ **4,250**	$ 4,250
FUND BALANCE		
Endowment	$ **4,250**	$ 4,250

See notes to financial statements.

STATEMENTS OF REVENUES AND EXPENSES—UNRESTRICTED FUND–WVSMA

	Year Ended December 31 1993	1992
REVENUES		
Dues	$ **738,458**	$ 748,995
Professional liability services—Note 5	**140,000**	140,000
Contributions:		
Legislative	**—**	8,495
Conferences and meetings	**8,996**	7,021
Interest and investment	**39,693**	41,002
Exhibit space income	**48,600**	51,200
Advertising	**44,877**	63,265
Registration fee income	**53,248**	42,705
Management fee income	**—**	5,000
Commission income	**26,771**	7,343
Other revenues	**15,474**	20,997
Total revenues	**1,116,117**	1,136,023
EXPENSES		
Salaries and wages	**282,377**	289,790
Legislative	**50,585**	43,981
Interest expense	**38,660**	50,951
Publishing and printing	**98,947**	91,777
Convention speakers and supplies	**90,201**	94,904
Legal and accounting	**89,007**	76,889
Travel	**72,874**	85,659
Malpractice	**38,884**	29,132
Employee benefits	**78,835**	68,531
Depreciation and amortization	**26,652**	28,250
Postage	**37,760**	37,556
Payroll taxes	**24,679**	24,011
Office supplies	**23,114**	23,804
Telephone	**17,806**	15,824
President's stipend	**9,500**	5,000
Property taxes	**13,129**	11,395
Liability insurance	**6,730**	7,106
Medical students'/residents' subsidies	**11,915**	6,665
Computer repairs and maintenance	**8,499**	6,630
Utilities	**6,236**	6,792
Other expenses	**88,538**	90,479
Total expenses—net	**1,114,928**	1,095,126
Excess of revenues over expenses before taxes	**1,189**	40,897
Income tax provision:		
Federal	**5,040**	—
State	**2,944**	—
	7,984	—
(Deficiency) excess of revenues over expenses	$ **(6,795)**	$ 40,897

See notes to financial statements.

STATEMENTS OF CHANGES IN FUND BALANCES–WVSMA

	Unrestricted Fund	Restricted Endowment Fund
Balance at December 31, 1991	$434,992	$4,250
Excess of revenues over expenses	40,897	1,520
Transfer from endowment fund to unrestricted fund	1,520	(1,520)
Balance at December 31, 1992	477,409	4,250
(Deficiency) excess of revenues over expenses	**(6,795)**	**1,536**
Transfer from endowment fund to unrestricted fund	**1,536**	**(1,536)**
Balance at December 31, 1993	**$472,150**	**$4,250**

See notes to financial statements.

STATEMENTS OF CASH FLOWS—UNRESTRICTED FUND—WVSMA

	Year Ended December 31 1993	1992
OPERATING ACTIVITIES		
(Deficiency) excess of revenues over expenses	**$ (6,795)**	$ 40,897
Adjustments to reconcile (deficiency) excess of revenues over expenses to net cash (used in) provided by operating activities:		
Depreciation and amortization	**26,652**	28,250
Gain on sale of investments	**(7,952)**	—
(Increase) decrease in accounts receivable	**(27,831)**	13,107
Decrease (increase) in other assets	**1,985**	(7,286)
(Decrease) increase in dues collected in advance	**(55,832)**	28,602
Increase (decrease) in income taxes payable	**294**	(4,832)
Decrease in medical scholarship obligations	**(4,500)**	—
Increase in accounts payable	**31,024**	163
Increase (decrease) in accrued expenses and other liabilities	**39,379**	(5,819)
Transfer from Endowment Fund	**1,536**	1,520
Net cash (used in) provided by operating activities	**(2,040)**	94,602
INVESTING ACTIVITIES		
Proceeds from sale of investments	**207,987**	—
Purchases of equipment	**(8,747)**	(7,143)
Net cash provided by (used in) investing activities	**199,240**	(7,143)
FINANCING ACTIVITIES		
Repayment of note payable to bank	**(10,431)**	(11,582)
Net cash used in financing activities	**(10,431)**	(11,582)
Net increase in cash	**186,769**	75,877
Cash and cash equivalents at beginning of year	**721,859**	645,982
Cash and cash equivalents at end of year	**$908,628**	$721,859

See notes to financial statements.

NOTES TO FINANCIAL STATEMENTS—WVSMA

1. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

Cash and Cash Equivalents: Cash and cash equivalents are comprised of short-term certificates of deposit and money market accounts recorded at cost, which approximates market.

Investments: In 1992, investments consisted of approximately 17,300 shares of a Federated GNMA Trust which are stated at the lower of cost or market value. There were no sales of investments in 1992. In 1993, all 17,300 shares of Federated GNMA Trust were sold with a recognized gain of $7,952.

Allowance for Doubtful Accounts: The Association values its accounts receivable at net realizable value by expensing amounts determined to be uncollectible in the period of determination.

Land, Building, and Equipment: Land, building, and equipment are recorded at historical cost. Depreciation is computed by the straight-line method using estimated useful lives ranging from 5 to 35 years. The cost of maintenance and repairs is charged to income as incurred, and significant improvements are capitalized.

Recognition of Revenue: Members are billed in advance for the subsequent year's dues, which are treated as earned in the period to which they relate. All dues received prior to January 1 are reported as dues collected in advance.

Other Deferred Revenue: In 1993, the Association received $57,000 in voluntary contributions from its members in support of pending litigation involving newly passed legislative rules and regulations which affect the practice of medicine in the State of West Virginia.

Medical Scholarship Obligation: Until 1987, the Association provided scholarships to students attending the Schools of Medicine at West Virginia and Marshall Universities for the purpose of defraying expenses incurred by such students. A liability for the remaining scholarship obligation is a part of the general fund.

Fund Balance: The Endowment Fund, a restricted fund, was established to pay for the guest speaker at the annual meeting and consists of equity securities stated at cost, which approximates market value.

Reclassifications: Certain amounts reported in 1992 have been reclassified to conform with 1993 presentation. Such reclassifications had no impact on excess of revenues over expenses as previously reported.

2. LAND, BUILDING, AND EQUIPMENT

A summary of land, building, and equipment, and the related allowance for depreciation as of December 31, is as follows:

	1993	1992
Land	**$ 141,247**	$141,247
Building and improvements	**635,585**	635,585
Furniture and equipment	**228,273**	219,526
	1,005,105	996,358
Less allowance for depreciation	**(381,650)**	(354,998)
	$ 623,455	$641,360

3. FUTURE MINIMUM RENTALS UNDER OPERATING LEASES

The Association leases office and computer equipment under noncancellable operating leases with terms of one year or more. The following is a schedule by years of minimum future rentals for the years ending December 31:

1994	$19,200
1995	11,300
Total minimum future rentals	$30,500

Total minimum future rentals do not include contingent rentals which may be assessed under the office equipment lease on the basis of usage in excess of stipulated minimums. Contingent rental expense in 1993 and 1992 approximated $7,000 for both years.

Rental expense in 1993 and 1992 approximated $32,000 and $27,000, respectively.

4. DEBT

Terms of the agreement underlying the note payable to bank provide for interest at 1% above the annual percentage yield of certificates of deposit and other balances, if any, securing the loan. The note is repayable in sixty monthly installments of $5,200 (including principal and interest) followed by a balloon payment or re-amortization of the loan. The loan is primarily secured by a first deed of trust on the building which has a net book value approximating $451,000 at December 31, 1993. In addition, the loan is collateralized by a $300,000 certificate of deposit and money market account with a balance approximating $523,000 at December 31, 1993.

Interest paid approximated $39,000 and $51,000 in 1993 and 1992, respectively.

Principal payments on the note payable in each of the next five years ending December 31 are as follows:

1994	$ 39,649
1995	41,594
1996	43,636
1997	45,777
1998	321,529
	$492,185

5. PROFESSIONAL LIABILITY SERVICES

The Association has separate agreements with Continental Insurance Agency (CNA) and McDonough Caperton Insurance Group, L.P. (MCIG) to provide educational and marketing services to the Association's members relating to professional liability insurance. Under the terms of the agreements, the Association is to receive up to $100,000 a year from each company. The Association recognized income of $100,000 from CNA and $40,000 from MCIG in 1993 and 1992.

6. RETIREMENT PLAN

The Association is a participant in a Prototype Corporate Defined Contribution Retirement Plan (the Plan). All employees of the Association are covered by the Plan as long as they are at least 21 years old and have completed six months of service. The Association's contribution approximated $31,000 and $23,000 in 1993 and 1992, respectively, based on 10% of the total compensation of all eligible participants. Employees are vested in their participant account at the rate of 20% for each completed year of service, up to 100% vesting after five years of service.

7. INCOME TAXES

Revenues of the Association are generally exempt from federal income tax under Section 501(c)(6) of the Internal Revenue Code. However, certain income, primarily advertising revenues and income received under agreements with insurance providers for their educational and marketing services and use of the Association's membership lists, is considered unrelated business income and is taxable to the extent it exceeds allocable expenses.

The Association paid income taxes approximating $7,000 and $4,800 in 1993 and 1992, respectively.

Obituary

James H. Nelson, M.D.

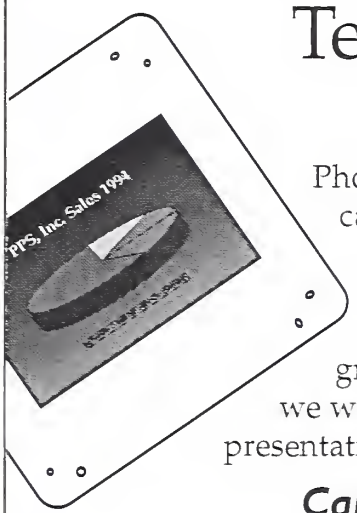
Dr. James Henry Nelson of Dunbar, a longtime Charleston area physician and the first black doctor admitted to the Kanawha Medical Society, died August 26 at General Division, CAMC, after a long illness.

A native of Hinton, Dr. Nelson was a graduate of West Virginia State College and Meharry Medical College. He did postgraduate studies at Columbia University and Temple University and served his internship at Agnes Hospital in Raleigh, N.C.

A former superintendent of Denmar State Hospital and former assistant medical director of Kanawha County Schools, Dr. Nelson had a family practice in Charleston and was a charter staff member at CAMC and Saint Francis Hospital. He was also a former school physician at West Virginia State College and a former house physician at Harrell Nursing Home and Washington Hotel. He had retired from practice in 1985.

During his career, Dr. Nelson received numerous awards, including the Mr. Doc Award in 1981 and the 1993 Martin Luther King Award. He was a 50-year member of the WVSMA and was a member of many medical and community organizations including the Kanawha Medical Society, National Medical Association, the American College of Chest Physicians, the American Academy of Family Physicians, the American Academy of Family Practice, and the West Virginia Medical, Dental and Pharmaceutical Society.

Surviving are his daughter, Barbara A. Carroll; and three grandchildren.



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Specialist in Electromyography and Nerve Conduction Studies

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Autumn splendor at the Sinks of Gandy in Webster County. Photo courtesy of *Ron Snow,* West Virginia Department of Commerce.

Access to medical care in West Virginia: Implications for policy

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Abstract

Access to medical care is an important goal of health care reform. In West Virginia, access to care has been defined in terms of insurance coverage and the availability of health care professionals, especially primary care practitioners. In recent years, three surveys have attempted to measure access to care. These surveys show that approximately 200,000 to 230,000 West Virginians needed medical care but were not able to obtain it because they could not afford it. A much larger number, about 540,000 West Virginians, put off or postponed seeking care they felt they needed because they could not afford it.

Introduction

Since 1991, West Virginians have been debating the issue of health care reform, and these discussions have focused mainly on the issues of cost and access.

This second factor, access, has been defined by the West Virginia Health Care Planning Commission as meaning both financial access (adequate insurance coverage) and the availability of primary care practitioners in rural areas of the state. Political leaders and the general public, though, have very different perceptions about access. In fact, some people state that there are 300,000 West Virginians who are without insurance coverage and that many more who have poor coverage lack adequate access to medical care -- while others maintain that hospital emergency rooms and private practitioners provide for charity care when it is really needed. Furthermore, some individuals believe that West Virginians who do not have insurance coverage are generally young and healthy and have no need of medical care beyond routine preventive care.

Another serious barrier to the availability of health care is the lack of primary care providers. All or parts of 43 counties in the state, mainly rural areas, have shortages of primary care physicians which create special hardships for the poor and the elderly who do not have access to reliable transportation. However, unpublished data cited by Dr. John Pearson at the West Virginia University School of Medicine shows that Medicare recipients in rural West Virginia have just as many or perhaps more hospital visits and procedures as their more urban counterparts (1).

In the past two years, three surveys have been conducted in West Virginia which have shed light on this issue of access to medical care and provided a better understanding of the extent of the problem. These surveys are:

- A Louis Harris Survey entitled West Virginia Health Care Experiences, which was conducted in West Virginia in May 1992.
- The Behavioral Risk Factor Surveillance Survey conducted by the Health Statistics Center of the West Virginia Bureau of Public Health, Office of Epidemiology and Health Promotion.
- The West Virginia Social Indicators Survey conducted by the West Virginia University Survey Research Center.

This article describes the results of each of these surveys as they relate to access to medical care and will reflect on some of the policy implications of the survey results.

Louis Harris Survey

The Louis Harris Survey was a one-time, cross-section telephone survey of 1,250 West Virginia adults which was conducted in May 1992 to obtain information about residents' experiences, fears, and concerns regarding health care and health insurance. This survey was similar to national surveys sponsored by the Kaiser Family Foundation and the Commonwealth Fund. It was funded by the Claude Worthington Benedum Foundation as a collaborative effort between the Health Care Planning Commission and the West Virginia Hospital Research and Education Foundation.

In the Harris survey, 13 percent of West Virginia adults -- the same proportion as nationwide -- said there was a time in the previous 12 months when they needed care but did not obtain it. Most said that financial reasons kept them from seeking care (45% said it "cost too much" and 31% said they were not covered by insurance).

The Harris survey made a further distinction between the individuals who needed care and did not get it, and those who were refused care. Ten percent of West Virginia adults reported that during the previous year they (3%), someone else in their family (6%), or both they as well as someone else in their family (1%) had been refused medical care because they did not have insurance or could not pay.

In the 12 months prior to the survey, 30 percent of the West Virginians questioned said they put off or postponed seeking care they felt they needed because they could not afford it. In addition, 12 percent of the individuals in households with children said they put off or postponed seeking care for a child in the 12 months prior to the survey.

Behavioral Risk Factor Surveillance Survey

Since 1984, the Health Statistics Center of the West Virginia Bureau of Public Health has participated in the Behavioral Risk Factor Surveillance System (BRFSS), which was developed and is funded by the Atlanta-based Centers for Disease Control. This survey provides data on health risk factors

including smoking, seatbelt use, alcohol consumption, hypertension, obesity and sedentary lifestyle. Starting in 1991, questions were added to the survey to address issues of health care coverage, access and cost. During 1991 and 1992, a total of 4,817 adults were asked if they had any type of health coverage and if there was a time in the past 12 months when they needed to see a doctor but could not because of cost.

The results showed that 16.1 percent of West Virginians ages 18 and older reported that they needed to see a doctor but could not because of cost. The survey did not distinguish between those who were refused care and those who did not seek care. The BRFFS survey is of particular interest and value because it is the only survey which allows for the calculation of rates by region. Figure 1 indicates variations from as low as 12 percent in the Northern Panhandle (District 6), to a high of 18.6 percent in the southwestern counties (District 2).

The BRFSS could be a valuable tool for helping state policymakers target resources to those areas with greatest need. It may also be beneficial in assisting policymakers to evaluate the impact of system reform efforts, such as the expansion of insurance coverage and the development of rural health networks.

WV Social Indicators Survey

The third survey measuring access to care in the state is the West Virginia Social Indicators Survey, which was begun in 1992. Conducted by the West Virginia University Survey Research Center, this annual survey gathers data on the social and economic conditions of West Virginians. In 1993, questions were added on insurance coverage, satisfaction with health care services, state government's efforts in addressing health care reform, and access to medical care.

During the fall of 1993, 961 West Virginia adults were surveyed. The results indicated that 10.9 percent of those responding had experienced a time in the past 12 months when they, or a member of their household needed medical care and did not get it. The survey did not ask for the reasons why medical care was not received.

Of those adults who responded to the survey, 81.5 percent had health insurance coverage, and of that number, 6.5% reported that there was a time in the past 12 months when they or a member of their household needed medical care but did not obtain it. In the same survey, 18 percent stated they had no insurance coverage, and of these individuals, 30.5 percent reported that they or a household member needed medical care but did not receive it (Figure 2).

Observations

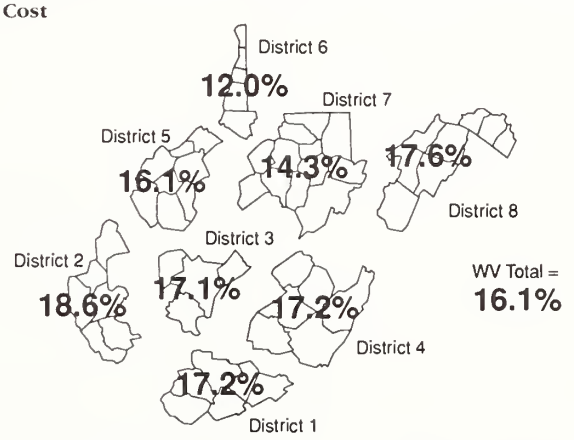
While these three surveys suggest a small variation in the severity of the problem of access to medical care, all surveys document that there is indeed a problem. They indicate that even West Virginians who have insurance coverage may have a problem in obtaining medical care when they need it.

It is especially important to note the results of the Harris survey which show that almost one-third or 540,000 West Virginians reported that they put off or postponed seeking care they felt they needed because of cost. We assume that people do not postpone care in an extreme or life-threatening situation; we also assume that not all care that people think they need is necessary or beneficial care. However, we are also forced to conclude that a substantial number of West Virginians have put off necessary preventive or primary care because they could not afford it.

These surveys have important policy implications regarding the issue of cost-sharing and also the goal of reducing the costs of health care. First of all, some health reform proposals suggest that increasing the financial responsibility of individuals through higher deductibles and co-payments, will cause consumers to be more prudent purchasers of care. The Harris survey suggests that increasing the financial burden on individuals will only increase the number of those who postpone seeking health care because of cost.

Any policy that attempts to control costs by discouraging West Virginians from seeking primary care may only confound another important policy

Figure 1. West Virginians* Who Said They Needed to See A Doctor But Could Not Because of the Cost



Source: WV Behavioral Risk Factor Surveillance System Surveys, 1991 & 1992, West Virginia Bureau of Public Health

*** Note: Adult respondents age 18+**

Figure 2. Access to Medical Care by Insurance Status - West Virginia, 1993

Source: WV Social Indicators Survey, 1993, WVU Survey Research Center

*** Note: Adult respondents age 18+ Unweighted data.**

goal of improving the overall health status of West Virginians. Preventive care and proper outpatient management of chronic diseases can prevent hospital admissions and more costly treatments.

A recent Robert Wood Johnson Foundation report states that "adequate and timely ambulatory care may prevent hospitalizations for such chronic conditions as asthma, congestive heart failure, and diabetes. Effective outpatient treatment of acute conditions – like pneumonia and cellulitis – may prevent complications requiring hospitalization. Such preventable hospitalizations are known as ambulatory sensitive (ACS) admissions." The report also states "that adults living in low-income neighborhoods are about three times as likely to be hospitalized for ACS conditions as people from high-income neighborhoods" (2).

This report and the three surveys suggest that policies to control health care costs should promote easy access to ambulatory care. Even though health services research is in its infancy and survey data requires cautious interpretation, it seems obvious that investing dollars in preventive and primary care now may save us millions later.

As West Virginians develop health reform policies, policymakers should avail themselves of the best research available and thoughtfully consider the implications of contradictory policy initiatives.

References

1. West Virginia Medical Institute. Unpublished Medicare data, 1992.
2. Center for Health Economics Research, The Robert Wood Johnson Foundation. Access to health care, key indicators for policy. Princeton, NJ: November 1993:66.

(Please see the editorial on page 479 relating to this article).

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Almost heaven?: Rural family practice in West Virginia

GREGORY JUCKETT, M.D.
Assistant Professor of Family Medicine, Robert C. Byrd Health Sciences Center of West Virginia University, Morgantown

It is commonly agreed that the United States is experiencing a rural health crisis, which is especially severe in West Virginia because of the large number of people living in poverty and the inaccessibility of much of our terrain. Most small towns are unable to afford primary care physicians, and those that do usually lose them in relatively few years.

As a result of the shortage of rural physicians, many people living in rural areas must drive long distances to hospital emergency rooms or use expensive "city" specialists for care. Medicaid patients, in particular, have had little choice besides utilizing emergency rooms since participating providers are few and far between. Those seeking obstetrical care may have even farther to travel since many rural hospitals no longer offer delivery services.

What has gone awry with rural health care? Some answers are obvious -- too few generalists, inadequate reimbursement, poor school systems, professional isolation, and physician burnout. Most of the last generation of old-time family doctors are either deceased or retired, and their ranks, for the most part, have never been replenished. There has been much talk about how to correct this sad situation, but until recently very few measures had been taken to actually improve the number of rural physicians. The increased talk of health care reform, though, has made primary care once again fashionable and the economic base for rural physicians somewhere brighter because of the possibility of universal coverage within the next several years.

Until recently, I was a rural family doctor. I still miss my patients and the rambling discussions about gardens, beehives, that eight-point buck that got away, and the many other topics pertaining to rural life. There was an illusion of indispensability and a definite certainty of purpose that made each day worthwhile. Rural life is a curious mixture of joy and sorrow -- joy at human bravery in the face of illness and hard work, and sorrow over the inevitable defeats that occur. Many patients, lacking education and insight, were trapped in a cycle of hopelessness from which they seemed powerless to extricate themselves.

A good example of this cycle of hopelessness is what could be termed "Appalachian wife syndrome." This is the situation where a young girl drops out of school and hastily marries due to an unplanned pregnancy, only to find herself stranded in a trailer at the end of a dirt road. After a few years, she becomes depressed because she is living in poverty with only young children for company.

Changing this situation poses real problems -- an absentee husband reluctant to enter (or afford) marriage counseling, no daycare facilities, no independent transportation, no driver's license or high school diploma, no job skills, and no phone. As a result of all of these difficulties, women in these types of situations lacked self confidence and believed that change was not possible. I found myself prescribing Prozac for these patients instead of trying to intervene in all aspects of their lives, thankful that Medicaid would paid the bill for such an expensive prescription.

Even though many of these women said they felt hopeless when I first started seeing them as patients, there were some remarkable successes, attributable mainly to individual courage in the face of adversity, not the effect of any medication. Of course, a script for birth control pills at just the right time could go a long way toward preventing an otherwise recurring problem. On these days, my job was incredibly satisfying in spite of the hardships.

Having made a list of the pros and cons of rural family practice, I must confess that the con list is longer -- at least at this time. The pros, however, have incalculable worth!

First of all, I was impressed by the decency and the kindness of my patients, who, for the most part, would give you the shirt off their back if they thought you needed it. There were a few exceptions, but they made up for it by being "interesting." The self-styled curmudgeons were my favorites.

In addition to the people, there are many other wonderful benefits to practicing in a small, rural town. There is a sense of timelessness and beauty about the land which can, in spite of its isolation, still move one to tears each spring. Can one put a price on encountering a flock of wild turkeys on the way to work, having lunch on a bank of wild trillium, or on hearing wild birds sing on the way home? There is also a sense of place and community that is enriching to the spirit in small rural towns. You feel centered after a time, and fondly imagine growing old in the town like the one I practiced in and developing deeper friendships as the seasons pass.

There is a price to pay, of course, for all of these amenities. Up front, you make less money -- lots less money. Many rural clinics are unable to pay much and hence attract only young doctors with heavy medical school debt (with promises of forgiveness) and foreign-trained physicians required to work in health manpower shortage areas. Mixed in with these physicians are a few locally-raised docs returning with real commitments to their community, and a few idealists with a Peace Corps mindset. Many move on after a few years because of professional isolation, dissatisfaction with income, boredom, or burnout.

There is also an unstated, but very real problem with personal privacy for any rural physician. It is often assumed that you will be willing, even eager, to discuss the most trivial medical problems. Many times you may be, but when every trip to the local grocery

store results in multiple consults, it inexorably wears one down. At times it is undoubtedly quicker to drive out of town to shop than to "run the gauntlet" at the local checkout counter.

Rural physicians in practice for themselves may find it especially difficult to have enough time for their families because of the demands of their patients. Since there are limited coverage options, many rural patients would often rather "drop by" their doctor's home in town than see an assigned doctor in the next town. Vacation coverage is extremely difficult, if not impossible, to obtain, usually costing far more than the practice can bear. It is often less stressful not to take a vacation!

Other factors to consider about practicing in a rural environment are the substantial Medicaid burden, high malpractice rates, and the mountains of mind-numbing paperwork -- the completion of which squanders countless precious hours. Bill collection too can be a real problem at times, especially when people have little or no third party coverage. When the coal miners and their families lose their insurance in the inevitable, protracted strike, the financial picture really gets grim. In addition, as rural hospitals in West Virginia fold one by one, many of the physicians associated with them are having to leave the local communities as well.

It is frustrating to note that physicians, health care administrators and hospitals are often their own worst enemies. Rural hospitals and their allied medical personnel repeatedly vie for each other's turf in a bizarre "dance macabre" that can terminate only with their mutual demise. It is as if we inhabit a shrinking pond and must rend each other in our attempts at survival rather than look to see who is siphoning off the water. A spirit of cooperation rather than competition is urgently needed. Unfortunately, some hospital administrators may have a natural tendency to place their job security and power over the interests of physicians and patients. A well-entrenched health care bureaucracy can, therefore, even with the best of intentions, fail to maximize health care in its region.

Last but not least, is perhaps one of the most overlooked reasons for a physician to depart a rural area -- an unhappy spouse. Just because the physician is content with a rural lifestyle doesn't mean that his/her spouse (usually met at an urban college or medical school) will be just as happy. There may be a dearth of friendships with those of similar educational backgrounds and interests. Poor, run-down, understaffed schools though, are one of the chief reasons why doctors and their spouses abandon rural practice, and I personally know of several colleagues who have left the state for this very reason -- concern for their children's education. In short, no placement will work unless the spouse is happy with the community, available education, social environment and their partner's work schedule.

With all of these problems, why am I optimistic about the future of rural health care in West Virginia? First of all, times are changing. As painful as national health care reform may seem, if it does become a reality within the next few years, it may help improve our state's shortage of rural physicians because the status of primary care providers would improve, making it more feasible to practice in a rural area. Of course, like most physicians, I am fearful of the loss of physician and patient autonomy, the inevitability of rationing in some form, and the prospect of increased taxes, all of which seem likely, if unstated, consequences of most of the plans proposed in Congress last session.

I first became convinced that there was a need for health care reform when a woman hemorrhaging from advanced cervical carcinoma came to my office in tears. There had just never been enough money in the family budget to cover the cost of groceries, let alone obtain pap smears. Her family had no health insurance and was already overburdened with medical debt for the children's care. Within a year, her children had no mother.

Unfortunately, this was not an isolated case. Several of my other patients died as a result of delaying care because they couldn't afford it, while others ended up suffering immense pain for long periods of time for this very same reason. It was also very frustrating and depressing for me to have to negotiate with elderly patients who had to make the terrible choice of either filling their costly prescriptions or eating properly because of their limited incomes. In addition, many of my younger patients held part-time jobs which did not offer health care benefits, and their incomes were not enough to purchase coverage. If they or a member of their families suffered from a chronic illness, it was actually financially and medically more advantageous to go on welfare than to continue to work!

If health care reform is to be worthwhile, it must address the problems I have mentioned. First and foremost, a network of rural health centers must be set up to reach specific underserved areas. Each community must have a major stake in its clinic and be heavily involved in providing its own health care to be effective. Since isolated physicians would still need assistance to prevent burnout, outreach from the nearest medical school (not control) could provide vital support with rotating faculty, residents and students. The universities could also provide continuing intellectual stimulation through evening CME programs and by offering visiting clinician programs. Both the clinics and the universities would benefit from this type of arrangement, which basically exchanges service for education.

Other measures, such as improving the school systems in the rural communities, trimming the bureaucracy and paperwork, ensuring reasonable incomes, passing tort reform to create a more favorable practice climate, and providing incentives for medical students to return to their communities after completing residencies, must be taken if rural practice is to become more attractive to medical students and residents. Some of these interventions have already been proposed, and a few have been implemented.

I feel that unless real reform takes place in the United States and West Virginia, it is futile, perhaps even immoral, to lure young physicians into what may be an untenable practice situations. While subsidies for rural clinics will undoubtedly be necessary for many years, I have fears that such support could abruptly dry up in a future budget crisis with disastrous results. What will happen to these clinics when rural health becomes less of a "hot" issue? A well-planned weaning period will be necessary if these fledgling clinics are to be successfully guided into maturity.

I have, for the most part, very happy memories of my years in rural practice. Like most aspects of life, you take the good with the bad and, with time, the better times overshadow the other. I do not regret practicing rural medicine for one minute, and I still have twinges of guilt at having left my small-town practice. Even though my present job has many advantages for my family and me, I find myself excited when discussing rural health with students and hoping that some of them will, in turn, be able to help transform the system in the near future.

Questions and answers about WVSMA's newly endorsed medical malpractice insurer

Editor's Note: Reaction has been overwhelmingly positive to the West Virginia State Medical Association's endorsement of Medical Assurance of West Virginia, Inc. as the professional liability insurer of choice. Physicians, though, have asked many questions about Medical Assurance and we are sharing some of them with you in order to increase understanding about this company and the coverage options they offer members of the WVSMA. If you have additional questions concerning this subject, please contact WVSMA Executive Director George Rider at (304) 925-0342.

Q: I'm happy that we have a strong, stable carrier committed to insuring West Virginia physicians, but will we have to pay for this stability through higher premiums?

A: No. Medical Assurance's premiums are lower than those of the carrier the WVSMA endorsed prior to Medical Assurance.

Q: Is Medical Assurance of West Virginia rated by A. M. Best?

A: Medical Assurance is rated A+ (Superior) by Best. This is a good yardstick by which to measure other carriers in West Virginia.

Q: Does Medical Assurance require me to make any contributions before I can become insured?

A: No. Medical Assurance's financial condition is so strong they don't have to require a surplus contribution.

Q: If I have a claim that I think should be defended, can Medical Assurance settle without my consent?

A: No! Medical Assurance is dedicated to the strongest possible defense, and their policy requires that the physician must consent to settle any claim. That's something that some carriers in West Virginia don't offer.

Q: I understand that West Virginia physicians will have a significant role in the insurance decisions made by Medical Assurance. How will this work?

A: Medical Assurance is a subsidiary of Mutual Assurance, Inc., one of the leading physician-founded malpractice insurers in the nation. Because of the company's background, Medical Assurance welcomes physician participation through organized Claims and Underwriting Committees. These committees will be your voice to the company.

Q: Is Medical Assurance going to insure everyone who is now in the WVSMA's sponsored program?

A: Yes! Medical Assurance has guaranteed first year acceptance for physicians who currently participate in the WVSMA program. After the first year of the program, Medical Assurance may underwrite physicians according to their standard procedures. Physicians switching from other carriers will be subject to underwriting review before initial acceptance.

Q: Will Medical Assurance provide *claims-made* and *occurrence* policies?

A: Medical Assurance will offer only *claims-made* policies. However, they have made special arrangements for physicians with occurrence policies to enter the Medical Assurance *claims-made* program.

Q: I have a *claims-made* policy. What about my retroactive date? Do I have to buy "tail coverage?"

A: Medical Assurance will accept the retroactive dates for all physicians who are currently insured in the WVSMA program. Physicians who are switching from another carrier to Medical Assurance should consult their agent, but should consider buying tail coverage.

Q: What type of discounts are available from Medical Assurance?

A: Medical Assurance offers a wide range of premium discounts, such as 10% for membership in the WVSMA. Physicians entering practice within two years of completing a recognized residency program will receive a discount of 65% in the first year of coverage, 35% in the second year. A five percent loss prevention discount will be applied at renewal following attendance at a Medical Assurance Risk Management Seminar; this discount will be good for two years. Initially, Medical Assurance will honor seminar attendance from the previously endorsed carrier.

Q: Will Medical Assurance offer the same limits I have now?

A: Medical Assurance will offer limits of $1 million per occurrence/$3 million yearly aggregate, but given the nature of the medical/legal system in our state, you are encouraged to consider the additional limits available — up to $11 million in $1 million increments.

Q: How do I make the switch to Medical Assurance?

A: Simply contact WVSMA Executive Director George Rider at (304) 925-0342 for details.

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Seventeen level laminectomy for extensive spinal epidural abscess: Case report and review

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Abstract

Several studies have suggested that non-operative treatment be employed for spinal epidural abscesses involving a considerable length of the vertebral column. The reasons for this have not been clearly stated in the literature, however, nor has the critical number of vertebral levels been specified. Presumably, this is related to the morbidity of extensive laminectomy, but we began to question this assumption because of advances in surgical instrumentation combined with frequent reports of irreversible disease progression while on appropriate antibiotics. In this article, we present a case of an extensive spinal epidural abscess managed surgically with no associated morbidity. In addition, we present a review of the literature concerning spinal epidural abscess.

Introduction

Spinal epidural abscess is a frequently misdiagnosed and potentially devastating condition, often constituting a neurosurgical emergency. Recent studies indicate that the incidence is increasing (1,2,3); and surgical treatment consisting of laminectomy and drainage of the abscess coupled with appropriate antibiotic therapy remains the mainstay of treatment (4,5).

Medical management has been recommended if the infection spans a considerable length of the vertebral canal (6), but the reasons for this are not made clear in the literature. Reports of disease progression while on antibiotics combined with the irreversible nature of the neurological deficit (1,5) makes medical management risky.

The abrupt onset of cardiorespiratory arrest from sepsis and neurological deficit in our patient while on appropriate antibiotics necessitated extensive laminectomy for drainage of an extensive spinal epidural abscess. This was accomplished with no additional morbidity to the patient.

Case report

A 27-year-old diabetic female was admitted to the Charleston Area Medical Center from a small rural hospital after a two-day history of nausea, vomiting, malaise, fever, dizziness and weakness. She also complained of pain in her lower back and buttocks on which was noted several draining skin abscesses secondary to chronic hidradenitis suppurativa.

Neurologic examination was unremarkable on admission. Blood cultures were obtained which grew methicillin-sensitive S. Aureus. Appropriate parenteral antibiotic therapy was then initiated.

Over the next two days, the patient remained febrile and developed nuchal rigidity and an altered mental status. Lumbar puncture was performed which revealed purulent CSF, and she was transferred to a tertiary care center with the diagnosis of meningitis.

Immediately after arrival at the tertiary care center, this patient suffered a cardiorespiratory arrest. Following resuscitation, she was unable to move her lower extremities. In view of the acute onset of paraplegia combined with the clinical picture, the diagnosis of spinal epidural abscess was considered. Frank pus was aspirated from the lumbar epidural space, confirming the diagnosis. Total cord myelography was performed by C1-2 puncture which showed narrowing from the mid-cervical spine to the sacrum, but no block. This was followed by CT

Figure 1A. Post myelogram CT of cervical vertebrae showing large extradural defect.

scan which revealed an extradural defect involving the same distribution (Figures 1A and 1B).

In view of her rapid deterioration and sepsis combined with the acute onset of paraplegia, laminectomy surgery was performed on this patient which revealed a large epidural abscess. Drainage and debridement of the abscess necessitated the removal of the laminae from the S1 to T2 vertebral levels. This procedure was accomplished in slightly over two hours using the Midas Rex instrument with the S1 bit (Figures 2A and 2B) as a laminar saw. No dural lacerations occurred and suction drains were placed in the epidural space prior to wound closure. Estimated blood loss was 500 ml. Figure 3 shows the radiograph taken postoperatively which demonstrates the extensive laminectomy defect.

Following the surgery, this patient was continued on parenteral antibiotics. She was eventually discharged home, but remained paraplegic until her death two years later, which was caused by an illness unrelated to her epidural abscess.

Discussion

Spinal epidural abscess remains a rare phenomenon. Since it was first described by Morgagni in 1769 (7), a few hundred cases have been reported in the literature. About one case per year is diagnosed in the average referral hospital (5), and studies have reported relatively stable incidences of spinal epidural abscess ranging from 0.2 to 1.2 patients per 10,000 hospital admissions (4,8). Recent studies, however, have suggested that the incidence is increasing.

Hlavin et al reported an incidence of 2.8 cases per 10,000 admissions over a 10-year period (1). Nussbaum et al also reported a steady increase in the incidence of spinal epidural abscess over a 10-year period, and in fact noted 11.31 cases per 10,000 admissions during the last nine months of their study. The authors concluded that this was likely due to an increase in the usage of illicit intravenous drugs, which was documented in 40 percent of their patient population (2,3). Other possible explanations include the growing number of spinal procedures such as surgical decompression and stabilization, spinal anesthesia, and local injections for pain relief (1,9,10,11,12).

Predisposing factors to the formation of epidural abscesses are

Figure 1B. Post myelogram CT of thoracic vertebrae showing large extradural defect.

Figure 2A. Photograph of Midas Rex instrument with S-1 bit.

Figure 2B. Model illustrating use of Midas Rex with S-1 bit as a laminar saw for rapid laminectomy.

intraveneous drug abuse, diabetes mellitus, blunt spinal trauma, cirrhosis, alcoholism, chronic renal failure, chronic steroid usage, para or quadriplegia, and infection with the human immunodeficiency virus (1,3,4,5,11,13,14,15,16). Of these factors, diabetes and intraveneous drug abuse have demonstrated the greatest clinical significance in several studies (1,3,5,11,13,14,15,17,18).

The majority of patients are infected via hematogenous dissemination from a remote site of infection (1,19,20). A history of concurrent infection is found in 75%-85% of the cases (8). Skin and soft tissue infections remain the leading source and were the cause in this patient.

Paraspinal infections after spinal procedures have also been reported, not only after open operations but also after closed procedures such as epidural anesthesia, local injections for pain relief, and lumbar puncture (1,10,12). Infected vascular access, urinary tract infection and dental abscesses represent less frequent sources (5,1). In addition, contiguous spread of infection to the epidural space has been reported from vertebral osteomyelitis, as well as decubitus ulcers and psoas or paraspinal abscesses (4,5,16,17).

Gram negative organisms are found in less than 15 percent of cases, although the incidence appears to be increasing. Gram negative infections were initially reported to be in higher association with intravenous drug abuse, but this has not been confirmed in the most recent studies (1,18). Fungal epidural abscesses have also been reported, although much less frequently (11).

The clinical presentation is highly variable, which results in initial misdiagnosis in up to 50 percent of the cases (9). This, in turn, results in long delays between presentation and appropriate treatment. The course of spinal epidural abscess is described as having these four stages:

(1) Spinal ache
(2) Root pain
(3) Weakness
(4) Paralysis

Headache and nuchal rigidity may also be present (8,17). In addition, the majority of patients present with non-specific complaints such as fever and malaise (1,3,4,5,20). Weakness or paralysis may not develop for several months, or may occur suddenly (21), as was the case with our patient.

The mechanism of the often abrupt onset of neurological deficit remains poorly understood. Autopsy evidence has indicated that mechanical cord compression by the abscess is not an adequate explanation, since not all postmortem specimens have showed evidence of cord compression in proportion to the clinical picture (22).

Others support the concept of a vascular mechanism. Russel et al observed venous compression with preservation of the arterial supply, thrombosis and thromophlebitis of the epidural space and cord, and venous infarction and edema of the cord (23). Hlavin et al proposed that this theory could explain the rapidity of onset, the irreversibility, and their observation of a "central cord" pattern in one of their patients (1).

Early diagnosis of epidural abscess is crucial for a good outcome. The presence of fever with spinal pain and tenderness should suggest the diagnosis, particularly if a predisposing factor or source of infection is present (20). Gadolinium magnetic resonance imaging is the preferred radiologic examination, allowing direct visualization of the intervertebral disks, spinal cord, and soft tissues including the abscess itself. Myelography followed by CT scan is an alternative and should be used if bacterial meningitis is suspected, since MRI poorly distinguishes the subarachnoid space for the surrounding epidural tissues (18,24). Since bacterial meningitis was suspected in this patient, CT-myelography was chosen over MRI as the most appropriate study. Plain radiographs are largely unyielding and are not useful as a screening procedure (1,17,20).

Recent studies continue to support immediate decompressive laminectomy accompanied by appropriate parenteral antibiotic therapy as the treatment of choice for localized abscesses (1,3,5,15,17,20). Garrido and Rossenwater have reported success with the suction-irrigation technique as an adjunct to surgery (25), but the majority of recent series report no experience with this.

Several small studies have reported success with non-operative management (6,13), but the authors acknowledge that their patient populations had less severe neurological impairment at the time treatment was instituted with antibiotics. However, Hlavin and colleagues noted that 9 of 39 patients in their series progressed to greater neurologic deficit while on appropriate antibiotics (1), as was the case with our patient.

Figure 3. Plan radiograph taken after surgery which shows the extensive laminectomy defect.

Leys and colleagues stated that any patient who experiences rapid neurological deterioration should undergo surgery immediately (6), but they recommend that the following patients with epidural abscesses receive medical management exclusively:

(1) Those who are poor surgical candidates because of severe concomitant medical problems,
(2) Those who have abscesses that involve a considerable length of the vertebral canal,
(3) Those not suffering severe loss of spinal cord or cauda equina function; and
(4) Those who have remained completely paralyzed for more than three days.

The surgical procedure consists of decompressive laminectomy with drainage and debridement of the involved area. As stated previously, Leys and colleagues recommend that surgery should not be performed for abscesses involving a considerable length of the vertebral canal, unless the patient experiences rapid neurological deterioration (6). We feel that this approach is problematic in view of the irreversible nature of the neurologic deficit, as well as the documented tendency of the condition to progress while on appropriate antibiotic therapy.

In addition, the literature has not elaborated on the reasons for avoiding surgery in this situation, or the critical number of vertebrae involved that should preclude operative management.

Several studies have reported patients with large epidural abscesses

involving much of the vertebral column, but it is if these patients underwent surgery and what was the outcome, since only cumulative statistics were provided (4,5,3). We suspect that non-operative therapy was recommended to avoid the morbidity of such an extensive laminectomy. However, by using modern pneumatic instrumentation (Midas Rex instrument with S-1 bit), we were able to accomplish a laminectomy from S1 to D2 in approximately two hours, with a total blood loss of 500 ml. Our hospital course was free of morbidity related to the operation; and at the time of her death two years after discharge, she exhibited no evidence of spinal instability.

Instability after extensive laminectomy has been a concern, but this does not seem to occur commonly (15). Exceptions include children in which an extensive laminectomy is not recommended (25), and in cases of vertebral osteomyelitis with vertebral body destruction, in which case stabilization may be required (15).

Conclusion

The prognosis of spinal epidural abscess best correlates with the degree of neurological deficit at presentation and the delay in correct diagnosis and treatment (14). Mortality in several recent studies has ranged from 5%-23% percent, which shows considerable improvement over earlier studies. This is felt to be due to continued improvement of antibiotic agents and heightened awareness leading to earlier recognition (17).

We feel that the unpredictable and often devastating course of this illness combined with improved surgical instrumentation necessitates further investigation into the role of early surgical intervention in treating extensive spinal epidural abscesses.

Disclosure

The authors wish to state that they have no financial interest in any product mentioned in this article.

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An overview of adulthood attention deficit hyperactivity disorder

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Abstract

Attention deficit hyperactivity disorder (ADHD) in adulthood has become an increasingly recognized and clinically significant psychiatric syndrome. This article reviews the criteria for diagnosing adulthood ADHD, secondary complications of the disorder, and pharmacological methods for treating this disorder.

Introduction

Attention deficit hyperactivity disorder (ADHD) is a behavioral disturbance characterized by inattentiveness, impulsivity, and hyperkinesis. Although historically considered by clinicians to be limited to childhood, evidence now suggests that ADHD symptoms persist into adulthood to a significant degree (1,2,3).

Retrospective and prospective research studies indicate that between 31% and 66% of adults with a history of childhood ADHD continue to have symptoms of the disorder (4). Since the prevalence of ADHD among school-age children may be 3% or more, ADHD may be found in at least 1% to 2% of adults (5).

Attention deficit hyperactivity disorder can negatively impact many areas of adult functioning. Compared to matched controls, adults with a history of childhood ADHD have lower self-esteem, less formal education, and inferior work records (6). The potentially high prevalence of ADHD in the adult population and its negative implications upon adult functioning underscores the importance of educating all health care providers about this syndrome.

This article describes the criteria for diagnosing adulthood ADHD, concurrent psychopathology, and treatment with an emphasis on psychopharmacology.

Diagnosis

Despite attempts by researchers to validate the diagnosis of adulthood ADHD, the syndrome remains a diagnostic orphan for several reasons.

First, many clinicians who treat adults believe that ADHD always disappears by adolescence, so they do not consider it in adult treatment settings (7). Secondly, the process of retrospectively establishing a diagnosis of childhood ADHD based upon the patient's ability to recall symptoms that occurred many years previously, has dubious reliability (7,8). Finally, the DSM-III-R (9) criteria for the diagnosis of ADHD includes many behaviors specific for children, such as "difficulty playing quietly, intrudes into other children's games, difficulty awaiting his/her turn in games," and, therefore, does not differentiate between ADHD in childhood versus adulthood.

Although not yet recognized as a tool for clinical office practice, Paul Wender, M.D., and associates at the University of Utah have devised research criteria for identifying adults with ADHD for the purpose of conducting pharmacological studies. These criteria, referred to as the "Utah criteria," first require the establishment of a history of ADHD in childhood, and secondly, the presence of the following two characteristics in adulthood:

1. **Persistent motor hyperactivity** such as the inability to relax, inability to persist in sedentary activities like reading or watching television, and dysphoria when inactive.
2. **Attention deficits** manifested by the inability to keep one's mind on a conversation, reading materials, or his/her job; and also distractibility and forgetfulness demonstrated by actions such as losing or misplacing items.

In addition, at least two of the following characteristics must be present to diagnose ADHD according to the Utah criteria by Wender and his associates:

1. **Affective lability** with mood swings over hours to a few days that range from being bored and discontented to being excited.
2. **Inability to complete tasks** which includes a lack of organization at work or at home, the inability to solve problems, manage time, and concentrate on one task at a time.
3. **Temper problems** such as being irritable, easily provoked, and explosive.
4. **Impulsivity** such as non-reflective decision making, which also results in turbulent work performance and personal relationships, antisocial behaviors and reckless pleasure-seeking activities.
5. **Low tolerance for stress** which results in depression, anxiety, confusion or anger from just having to deal with typical everyday situations.

According to the Utah criteria, the diagnosis of ADHD is preempted by diagnoses of schizophrenia, schizo-affective disorder, primary affective disorder, and schizotypal or borderline personality disorder (10).

Concurrent psychopathology

In a profile of 56 adults (ages 19 to 65 years) who met the Utah criteria for ADHD, Skekim and colleagues (2) found that 53% of the adults also met criteria for generalized anxiety disorder, 34% for alcohol abuse or dependence, 30% for drug abuse, 25% for dysthymia, and 25% for cyclothymic disorder. Only 14% of the adults had the diagnosis of ADHD alone, and one third had four DSM-III-R diagnoses in addition to ADHD. Also, ADHD appears to be a frequent underlying factor in the development of pathological gambling (11,12).

Many outcome studies have found that ADHD in childhood can lead to antisocial behaviors in adulthood (6,13). Studies differ greatly, however, on the percentage of adults who are antisocial (ranging from 10%-55%), and on the severity of the antisocial behaviors (3). The connection between ADHD and antisocial disorders in adults appears to be indirect, but it has been shown that aggressive behaviors are the most common way that antisocial tendencies manifest themselves (14).

Bellack and colleagues (15) advanced the hypothesis that certain psychoses in adults evolve from ADHD, secondary to an impact upon social and cognitive development so extreme as to produce disturbances in reality testing, self-image and judgment. These ADHD-related psychoses are often misdiagnosed as schizophrenia or an affective disorder, precluding appropriate clinical intervention.

Treatment

The treatment of adults with ADHD can be divided into pharmacological and non-pharmacological interventions. Several controlled studies exist which explore the efficacy of various medications, but controlled studies of non-pharmacological treatments have not been conducted. The importance of non-pharmacological treatments should not be undervalued, however, considering the significant complications associated with this disorder. Through psychotherapy, problems like low self-esteem, emotional and social isolation, feelings of rage, procrastination, and avoidance of difficult tasks can be addressed in a constructive manner (5).

Methylphenidate is the recognized first-line pharmacological intervention for adulthood ADHD, and is thought to act by increasing the concentrations of dopamine and norephinephrine at the synaptic cleft (5). Wender et al (16) entered 37 adult patients meeting Utah criteria for ADHD into a double-blind crossover trial of methylphenidate versus placebo. Therapeutic improvement occurred in 57% of the patients receiving methylphenidate compared to only 11% of those receiving placebo. The patients who responded to methylphenidate showed significant improvement in the areas of impulsivity, attentional difficulty, motor overactivity, and affective lability. The final dosage range for methylphenidate was 10-80 milligrams/day.

Gualtieri et al (17) conducted a similarly designed study of 12 adult male patients with ADHD using a methylphenidate dose of 0.3 milligrams/kilogram b.i.d., and observed an improvement in concentration and a decrease in restlessness compared to placebo. However, the findings of this study and those of Wender are contrary to the results of research by Mattes and colleagues (18), who conducted a double-blind crossover design study of methylphenidate with 26 adult patients with a childhood history of ADHD. Their findings revealed no overall benefit in taking methylphenidate when compared to a control group of 35 adults without a history of ADHD. More controlled studies of methylphenidate are needed before its therapeutic efficacy in adulthood ADHD can be clearly determined.

Other stimulant medications with possible applications for adulthood ADHD include d-amphetamine and pemoline. To date, no controlled trials of d-amphetamine have been conducted, although, it does have a potential advantage over methylphenidate due to a longer duration of action. Pemoline has been studied in the treatment of adulthood ADHD and found to be more effective than a placebo, but its clinical use is hampered by a relative shortage of controlled studies demonstrating efficacy; a side effect profile that includes agitation, headache and insomnia; and a 2%-3% incidence of the development of elevated liver enzymes (10).

The clinically recognized second line of drug treatment for adulthood ADHD has up until recently been the tricyclic antidepressants imipramine and desipramine (19). A review of the current literature reveals a surprising lack of controlled studies on the use of tricyclics for adulthood ADHD. However, another medication which has received increasing interest is the antidepressant bupropion.

Wender and Reimherr (20) prescribed an open trial of bupropion for 19 adults with ADHD and found that 14 of the adults experienced significant benefit, and 10 of these patients preferred to continue this medication instead of starting back on their previous treatment of stimulants or monoamine oxidase inhibitors. The authors theorize that bupropion's efficacy is based upon its dopaminergic activity. The mean dose of bupropion for the 14 adults who experienced benefit was 359 milligrams/day, with a dosage range of 150-450 milligrams/day.

Several other medications have been used to treat adulthood ADHD, with varying results. The monoamine oxidase inhibitors pargyline and L-deprenyl have been studied, but were found to have limited therapeutic benefits, particularly when compared to stimulants (21). Propranolol was found to decrease the frequency of temper outbursts and other symptoms of ADHD in a trial of 13 adults, which sugggests a need for more controlled studies (22). The anxiolytic buspirone has also been postulated as a useful treatment based upon its presynaptic dopamine antagonist properties which increase the firing rate of midbrain dopaminergic neurons, and thus increase dopamine concentration at the synapse (23). In addition, fluoxetine, clonidine, thioridazine, carbamazepine and lithium carbonate have been shown to have some efficacy in treating adulthood ADHD (24).

Conclusion

Adulthood ADHD is an increasingly recognized syndrome with great potential to disable many facets of an adult's life. Prompt diagnosis and appropriate intervention are the greatest weapons against the damaging effects of this disorder.

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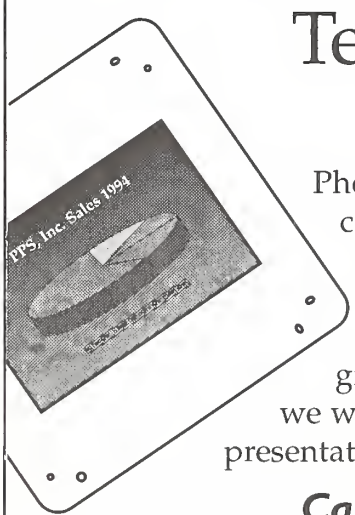

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A spontaneous esophageal perforation and duodenal ulcer perforation resulting in a subpulmonic abscess

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Abstract

Both spontaneous esophageal perforations (Boerhaave syndrome) and duodenal ulcer perforations are medical emergencies. Spontaneous esophageal perforation (SEP) is the most serious and rapidly lethal perforation of the gastrointestinal tract. Prompt diagnosis and early therapy is needed to prevent death or prolonged serious illness, and the key to the diagnosis is an awareness of its frequent atypical presentations. This article presents a case report of SEP and duodenal ulcer perforation which caused a right-sided subpulmonic abscess and reviews the literature pertaining to this subject.

Case report

A-36-year-old man presented to the emergency room with a two-week history of fever, chills, night sweats, non-productive cough, shortness of breath, and right-sided pleuritic chest pain. He had been seen at a clinic 10 days earlier and was diagnosed with "pneumonia." Three days prior to arriving at the emergency room, his stools became "loose and tarry."

This patient had a temperature of 38.8°C and he had an orthostatic drop in blood pressure. Chest examination revealed lower zone dullness to percussion and decreased breath sounds bilaterally. Mild right upper quadrant abdominal tenderness was noted, but there was no rebound or guarding. Stool tested positive for blood. Other blood work showed his white blood cell count was 34.5 with 63% neutrophils and 19% bands; and his hemoglobin was 6.7 gm/dl, hematocrit 19.7%, with a platelet count 1,191.

The chest radiograph (Figure 1) revealed a large air-fluid structure at the right lung base which was confirmed by thoracic computerized tomography, so broad spectrum antibiotics were prescribed. Under computerized tomography guidance, percutaneous drainage of the fluid was performed (Figure 2), and the fluid culture revealed beta Streptococcus, group C. Bronchoscopy showed no abnormalities.

After the patient had been stabilized, further history revealed that he had been drinking alcohol and had vomited three times prior to the initiation of his symptoms. A perforation was considered; however, gastrografin swallow did not reveal any communication between the right lung base, esophagus and stomach. Esophagogastroduodenoscopy showed two duodenal ulcers located posterolaterally at the junction of the first and second portion of the duodenum.

This patient was initially felt to have a right lung abscess, and despite therapy, he continued to have fevers to 39°C with a leukocytosis of 20.0. A right thoracotomy was performed which revealed normal pulmonary parenchyma and a subpulmonic abscess extending across the mediastinum into the abdomen. In addition, intraoperative esophagogastroduodenoscopy demonstrated a distal esophageal perforation.

The right thoracotomy incision was closed and a left thoracoabdominal incision was made. A perforation of the posterolateral duodenal ulcer was found which tracked superiorly into the lesser sac. An inflammatory reaction behind the portal vein leading towards the thorax was noted. A vagotomy and pyloroplasty were performed in addition to an omental patch repair of the distal esophagus.

Figure 1. Posteroanterior chest radiograph shows an 8 cm. ovoid cavity with air-fluid level at the right lung base. There is also a left pleural effusion.

Figure 2. Thoracic CT scan with percutaneous catheter lying within an abscess cavity at the right lung base.

After a complicated hospital course, this patient was discharged in stable condition and he has done well at 15 months in follow-up.

Discussion

This is a rare case in which the patient had both a spontaneous esophageal perforation (Boerhaave's Syndrome) and a perforation of an intra-abdominal viscus in the duodenum, which caused abscess formation in the right thoracic cavity.

SEP was first described in 1724 by the Dutch physician Boerhaave. He described a patient who developed sudden excruciating chest pain while straining to vomit, and then went into shock and died (1). The first successful surgical repair was performed in 1946 by Barrett (2).

History is of paramount importance and the classic presentation is of a middle-aged man, often with a background of alcoholism or dietary excess, presenting with these symptoms:

1) vomiting
2) lower thoracic pain
3) subcutaneous emphysema

These three symptoms have been classified as Mackler's Triad (3). To this triad may be added pneumomediastinum, or the presence of air-fluid in the pleural cavity.

Although SEP is classically post emetic, there are numerous reports of it occurring without vomiting or pain. This condition has been found to occur as a result of asthma, childbirth, sleep, a food binge, laughter, heavy lifting, prolonged coughing, hiccups, straining at stool, or after the Heimlich maneuver and trauma.

Review of the medical literature reveals that SEP continues to be frequently missed. Approximately one third of all cases are clinically atypical (4). The most common initial misdiagnoses include myocardial infarction, pneumonia, pancreatitis, lung abscess and pulmonary embolism (5).

Chest radiographs should not be depended upon to diagnosis SEP (6). A helpful finding is mediastinal emphysema. Unfortunately, this takes approximately one hour to develop and is present in only 40% of the patients with SEP. In adults, two-thirds of the perforations occur on the left side, 20% on the right, and 10% bilaterally (7). The diagnosis is usually confirmed by a contrast study of the esophagus showing extravasation, but 10% of these studies may be falsely negative (8). The examination should be repeated if clinical suspicion is high, and the treatment of choice is surgical closure of the perforation within 24 hours. After 24 hours, survival decreases to less than 50% (9).

Although SEP is uncommon, it is not rare. Unfortunately the proportion of undiagnosed cases discovered at autopsy remains high. Improvements in medical technology have not been paralleled by increasing diagnostic accuracy (10). Clinicians need to be alert to this lethal disease and be aware of its frequent atypical presentations.

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All manuscripts should include:

1. Title page
2. An abstract of no more than 150 words
3. Text
4. Acknowledgements
5. References in parentheses numbered consecutively. No more than 25 references will be published free of charge.
6. Tables
7. Legends for illustrations

All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the concept.

Where reference is made to generically-designated drugs, the first such reference must be followed by parentheses containing its most commonly known trade name.

Tables (tabular listings) and figures (photos, drawings and charts) should be numbered, and the point of reference in the text indicated in parentheses, i.e. (Table 1), (Figure 10). Photos must be unmounted glossy prints in a 5 in. x 7 in. format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be done in solid black on pure white.

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President's Page

"I want you!"

Even though I look nothing like Uncle Sam on the old recruiting poster (except for the fact that my hair is rapidly turning white), his words *"I want you!"* express exactly how I feel.

You may wonder what it is that you're needed for -- after all, your practice is busier than ever, your golf game is finally coming around, and that pesky specter of national health care reform is a bitter but rapidly fading memory. Not only that, but you've elected me as your president to watch over and take care of any little problems that arise. I thank you for your trust and support but, ennui and complacency are our biggest enemies.

I want you now, not tomorrow or next year, to become **INVOLVED.** Yes, I know this is a frightening concept for some of you, but I would like each and every one of you to sit down and think about what you as an individual, and what we as a group, can do to improve the future of our profession. It is in **YOUR HANDS**, not mine, that this future is held. I will be your spokesman, your weapon in the ongoing fight against the enemies of our profession and most importantly, our patients. But, I cannot and will not do it without your help.

Significant problems loom on the horizon. Managed (or more appropriately rationed) care is rapidly moving into our state, sometimes, and I find this hard to believe, with the assistance of our members. State government is also starting to socialize the medical care system it controls (PEIA, Medicaid, Worker's Compensation, etc). In addition, this administration seems intent on producing a health care bill with little or no input from us -- the physicians who actually provide the health care for our citizens. If this doesn't scare you it should.

I want you to be involved and I want to be effective. Divisiveness and cacophony will have no place during my presidency. Call me old fashioned, but a house divided cannot stand. **WE WILL SPEAK IN UNITY ON EVERY ISSUE OR WE WILL FAIL.** This is not to say there will be no discussion or dissent, but it will be in the proper forum and not in the press or public.

I want you to be more active in your communities, in your component societies, the WVSMA, and in the political process. Talk to your patients, your friends, and your politicians. Let them know how you feel about the issues surrounding our profession. But, and I can't emphasize how important this is, listen to and be interested in what they have to say; otherwise your message will fall on deaf ears. And, most surprisingly, you may learn something that may help you understand why people feel so strongly about this thing called medical care.

Please, help me preserve and enhance the practice of medicine in West Virginia.

Dennis M. Burton, M.D.

P.S. IF YOU DON'T BECOME INVOLVED, DON'T BOTHER TO CALL ME LATER AND COMPLAIN ABOUT THE OUTCOME.

Access to medical care

Our first feature article this month, *"Access to Medical Care in West Virginia: Implications for Policy,"* offers an opportunity to examine health system research, its potential value and its potential for misleading conclusions. Throughout this article, the authors are quite candid in pointing out the limitations of the studies cited, but the studies lend themselves to easy out-of-context quotes which lead to distortions of their actual findings.

The studies make no distinction between emergency care and any other type of medical care so that we do not know what the individuals polled regarded as needed or desirable. Is it chiropractic care they feel was needed and unprovided, or some form of "alternative" care? Perhaps it was for a problem the benign neglect of which would have produced a cure as quickly and at a significant cost savings to our total national health care bill. Many, many misplaced and inappropriate items appear beneath the rubric **medical care costs.** A good argument can be made that beyond emergency medical care, further elements down the list of medical care possibilities very quickly become luxury or optional items.

There were several mildly surprising and reassuring findings about West Virginia brought out in the several polls. Among these is the finding that far from being neglected, Medicare recipients in rural West Virginia have as many or more hospital visits and procedures as their urban counterparts. Another interesting finding reveals that health service statistics in West Virginia do not vary in any significant way from those found nationally. The results of the health care reform debate during the past year suggest that these statistics are acceptable to the great majority of Americans.

We certainly agree with one of the concluding comments in this article *"...health services research is in its infancy and survey data requires cautious interpretation."* We also totally agree with and endorse the final paragraph, *"As West Virginians develop health reform policies, policymakers should avail themselves of the best research available and thoughtfully consider the implications of contradictory policy initiatives."*

– SDW

The election

"The morning after" can connote either a thumping headache, nauseous feelings in the stomach, regrets over the previous night's activities or the pleasant recall of recent pleasurable orgiastic experiences. The morning of November 9th provided occasion for both, depending on which political party one happens to espouse.

That day also provided occasion for political pundits of the media and both political parties to explain the previous day's events. All appeared defeated by the task. There appeared to be unanimity that the electorate had sent a message that it wanted "change." That same explanation seems to have accounted for the results of every election for perhaps as long as we have had elections.

It seems far more likely that the real message from the voters is that they have endured far too many changes in recent years, and that most of these have been disappointing at best. I think the unspoken message is that it is time to reflect on tradition and history, our family and cultural values; time to stop trendy, politically correct edicts; and time to compare what we appear to be acquiring in this nation with what we have had in the past.

It is perfectly clear, as most of the pundits seemed to grasp, that the American people have had enough of the paternalistic and intrusive efforts of our federal government to further dominate our lives. In this respect, a clear message has been sent to those political professionals in the habit of responding attentively to every instruction of Liberal gurus. No politician can afford to miss that message.

In West Virginia, we happily note an early beginning at acquiring some semblance of badly needed political balance for our state.

– SDW

A difference of opinion on endorsements

Like other states with low levels of education, high union affiliation and a constant exposure to class warfare, Republican candidates often perform frustratingly less than satisfactorily in West Virginia. Your calling the party "impotent" in the *West Virginia Medical Journal* may be a bit strong however.

One of our greatest impediments in building a stronger political balance is our inability to persuade interest groups like the WVSMA from endorsing the very same legislators who have opposed the medical profession. Groups like yours argue that through their contributions perhaps the liberal Democrat leadership won't be too harsh on them. Haven't you all learned anything from history? Isn't there a psychological term for this?

The following selections are incumbents endorsed by the WVSMA even though their voting records on 10 medical issues were 33% or less. Two times out of three times they opposed your position! These issues were selected in concert with the WVSMA:

District	Incumbent		Leadership in House
1st	Tamara Pettit	30%	
4th	Scott Varner	0%	
5th	David Pethtel	0%	Vice Chairman - Constitutional Revision
15th	Margaret Leach	0%	
16th	Steve Williams	30%	Chairman - Banking
17th	Kenneth Adkins	33%	
19th	Larry Heck	10%	
27th	Robert Kiss	0%	Chairman - Finance
30th	Joe Farris	10%	
37th	Joe Martin	0%	Chairman - Government Organization
37th	Bill Proudfoot	20%	
44th	Robert Beach	0%	Chairman - Agriculture
46th	David Collins	0%	Vice Chairman - Political Subdivision
50th	Jerry Mezzatesta	0%	Majority Whip

Only by working in a coordinated effort with affected groups can we achieve political balance in this state. We have had soloists sing their song and get some recognition; but imagine the difference if we had a choir. Many of us are committed to achieve that objective.

Recently, I addressed the WVSMA Alliance in Ohio County. There I listed several planks on which we find mutual agreement:

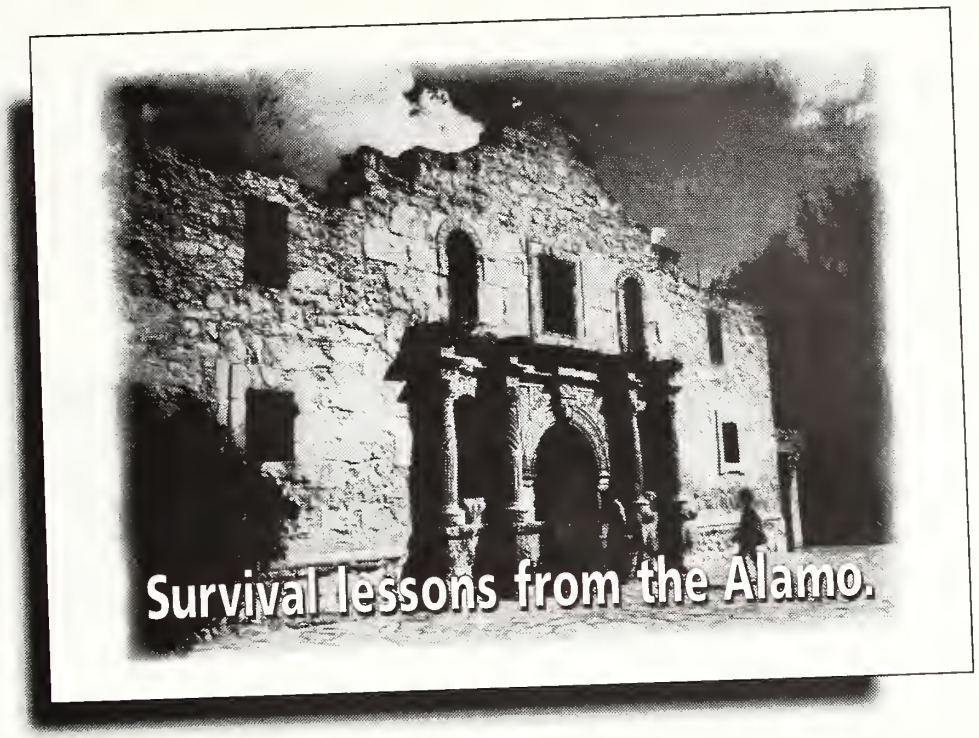
- Tort reform
- Individual accountability for personal lifestyles and choices, i.e. obesity, smokeless tobacco, sedentary lifestyle and teenage pregnancies
- Elimination of Medicaid tax on all providers
- Insurance reform
- Violence within our families and threats to our children

During these remarks, I alluded to my ongoing evaluation of a 1996 gubernatorial race. Mary and I have crisscrossed the state in an effort to ascertain whether a conservative businessman and yes, a Republican, can win. In addition, we have already hired one staff person and two nationally recognized consultants. You seem to have concluded that our party is incapable of grasping this goal; nevertheless, I would appreciate the opportunity to dissuade you.

Let me also congratulate your bold editorial statement in the October issue of the *West Virginia Medical Journal*. There are ample reasons *"to break all ties with the Democratic Party."* We need to be prepared to be the alternative.

Thank you for your political insight.

David B. McKinley
Wheeling



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Experience a new way of thinking about the future.

This year's conference, "Physician Empowerment and Teamwork in a Changing Environment," will help you experience a change of perspective on the 21st Century.

Learn how to manage change.

During *Interactions*, we will address emerging trends in health care delivery and how best to manage them. Among the trends we will discuss are:

- Physician/hospital relationships
- Economic competition
- Physician autonomy
- Resource allocation
- Regulatory constraints

Gain new leadership skills.

Special emphasis will also be placed on developing and refining your strategic planning, team building, and communication skills. Each participant will learn how to be a more effective arbitrator, facilitator, manager, negotiator, problem solver, and peacemaker.

Your team leaders.

Sponsored by the *American Medical Association*, in cooperation with the *National Association Medical Staff Services* and the *Texas Medical Association*, this conference features well known experts from the health care field.

Who should attend.

The curriculum is designed to benefit experienced and newly elected or appointed medical staff leaders, including: chiefs of staff, department chairs, vice presidents of medical affairs, medical staff committee chairs, and medical staff services professionals.* Bring a team from your hospital!

For more information or to register, call **800 621-8335.**

* The AMA designates the *Interactions* conference for 18 credit hours of Category 1 of the Physician's Recognition Award of the AMA.

American Medical Association
Physicians dedicated to the health of America

At Mid-Winter

WV-ACP/WVSMA co-sponsored session to highlight "*Moving Points in Medicine*"

This year's First Scientific Session, "*Moving Points in Medicine*," at the WVSMA's Mid-Winter Clinical Conference will again be co-sponsored by the West Virginia Chapter of the American College of Physicians and will be presented on Friday, January 20 at 1:30 p.m. at the Radisson Hotel in Huntington. This session will feature five speakers and will be moderated by **Robert J. Marshall, M.D., F.A.C.P.**, governor of the WV-ACP.

The first scheduled lecturer for this program will be **Lawrence Frohman, M.D., F.A.C.P.**, the Edmund F. Foley Professor and head of the Department of Medicine at the University of Illinois, who will discuss the "*Use of Growth Hormone in the Adult and Aging Population.*" The next speaker, **Craig J. McClain, M.D.**, director of the University of Kentucky's General Clinical Research Center, will describe "*New Concepts in Gastroesophageal Reflux and Ulcer Disease.*" Following Dr. McClain's presentation, **Maurice A. Mufson, M.D.**, professor and chairman of the Marshall University School of Medicine, will speak on the subject of "*Lessons Learned from Vaccine Use During the Past 40 Years.*" This session will then conclude with a special lecture: "*Peripatetic Plastic Surgeons: Benefactors of Mankind or Innocents Abroad?*" which will be delivered by plastic and reconstructive surgeons **F. Anthony Wolfe, M.D.**, and **Deirdre M. Marshall, M.D.**, of Miami.

Information about these speakers begins below. A registration form for the Mid-Winter Clinical Conference appears on page 487, and more details about the meeting can be obtained by phoning Nancie Divvens at (304) 925-0342.

Frohman

Mufson

Wolfe

Marshall

Session presenters highlighted

Dr. Frohman is a graduate of the University of Michigan Medical School and received training in internal medicine at Yale-New Haven Medical Center and in endocrinology at Duke University Medical Center.

Before accepting his current post in 1992 as the Edmund F. Foley Professor and head of the Department of Medicine at the University of Illinois, Dr. Frohman was director of endocrinology and metabolism at the University of Cincinnati, where he was also director of the General Clinical Research Center. During his career, he has also held faculty positions at the State University of New York at Buffalo and the University of Chicago/Michael Reese.

Dr. Frohman's research has been supported by the NIH for the past 27 years, and his work has included studies of the neuroendocrine regulation of pituitary function, particulary on the hypothalmic control of growth hormone (GH) secretion. His laboratory was the first to document hypothalamic control of GH secretion, provide evidence for a hypothalamic GH-releasing factor, and to identify and characterize this factor in extra-pituitary tumors associated with acromegaly.

The recipient of the Endocrine Society's Rorer Award for Excellence in Clinical Investigation in 1991, Dr. Frohman currently serves as the Bane Scholar at the University of Illinois. He is the author of more than 300 scientific publications, and is an editor of the textbook *Endocrinology and Metabolism.*

Dr. McClain is a graduate of the University of Tennessee School of Medicine. He completed his internal medicine residency at the University of Pittsburgh and a fellowship in gastroenterology at the University of Minnesota.

In 1982, Dr. McClain joined the faculty of the University of Kentucky as director of gastroenterology. He assumed an additional role at UK in 1992 when he was named director of the NIH-funded General Clinical Research Center.

Dr. McClain has extensive research interests and is involved with ongoing projects involving micronutrients, cytokines, eating disorders, ulcer disease and metabolic abnormalities in trauma and alcoholic liver disease. He has published more than 120 peer-reviewed manuscripts, as well as over 45 other articles and book chapters, and is a reviewer for numerous journals.

A speaker at many national and international symposiums, Dr. McClain received the Grace A. Goldsmith Award for Outstanding Research in 1990.

Dr. Mufson is a native of New York City who graduated from Bucknell University in Lewisburg, Pa., and from the New York University School of Medicine in New York City. He served as an intern and resident physician at Bellevue Hospital in New York City and as chief resident physician on the University of Illinois College of Medicine Service at Cook County Hospital in Chicago.

Dr. Mufson served with the U.S. Navy Medical Corps from 1959-61. He then became a Public Health Service Post-Doctoral Fellow in Infectious Diseases at the National Institutes of Health in Bethesda, Md., and in 1962 joined the U.S. Public Health Service as a commissioned officer.

In 1965, Dr. Mufson was appointed to the faculty of the University of Illinois College of Medicine, where he taught for 11 years and attained the rank of professor of medicine. Dr. Mufson relocated to Huntington in 1976, to become the first professor and chairman of the Department of Medicine at the Marshall University School of Medicine, where he has received both the University Scholar and the Meet-the-Scholar Award.

A fellow of the American College of Physicians, Dr. Mufson is also a fellow of the Infectious Diseases Society of America and is a member of numerous national medical societies. He was a recipient of the West Virginia Chapter of the American College of Physicians' Laureate Award in 1994.

This past June, Dr. Mufson was a visiting scientist in the Virology Department of Karolinska Institute of Medicine in Stockholm, Sweden.

Dr. Wolfe received his M.D. degree from Harvard University in 1965. He completed his internship at University Hospitals of Cleveland, and then did a residency in general surgery at Peter Bent Brigham Hospital in Boston and a residency in plastic surgery at the University of Miami School of Medicine.

Dr. Wolfe was awarded a Fulbright Scholarship for 1974-75 and served as an assistant to Paul Tessier, M.D., in Paris. In 1974, he also joined the faculty of the University of Miami School of Medicine, where he is presently a clinical professor of plastic and reconstructive surgery.

A fellow of the American College of Surgeons and a founding member of the International Society of Craniomaxillofacial Surgery, Dr. Wolfe is a member of many other medical organizations. He holds appointments at seven hospitals in the Miami area, and is a consultant in craniofacial surgery at the University of Florida in Gainesville and at the University of Texas Medical Branch in Galveston.

A noted author and lecturer around the world, Dr. Wolfe serves in editorial capacities for *Plastic and Reconstructive Surgery, Annals of Plastic Surgery, American Cleft Palate Journal, and International Pediatrics.*

Dr. Marshall is a native of Morgantown who obtained a B.A. degree in French literature from Yale University in 1983 and then attended Stanford University, where she received her M.D. degree in 1987. She completed an internship and residency in general surgery and in plastic and reconstructive surgery at Stanford from 1987-93. During this time, she also completed a fellowship in hand and microsurgery at the Institut Francais de la Main in Paris, and a fellowship in cosmetic surgery with Dr. Lawrence Robbins in Miami Beach.

Since July 1993, Dr. Marshall has been in private practice in plastic and reconstructive surgery in Miami, and has also been a clinical instructor at the University of Miami. She is on the staffs of six Miami hospitals and this year was named Attending Physician of the Year by the Miami Children's Hospital Nurses Association.

Dr. Marshall is an associate fellow of the American College of Surgeons and was a founding member of the American Society of Plastic and Reconstructive Surgery's Women's Caucus. Last year, Dr. Marshall was a featured speaker at the Fifth Biannual Meeting of the International Society of Craniofacial Surgery in Oaxaca, Mexico.

Physician/Public Session to focus on managed care

"Health Reform/Managed Care" will be the title of this year's Physician/Public Session on Friday, January 20 at 7 p.m during the WVSMA's Mid-Winter Clinical Conference at the Radisson Hotel in Huntington. Panelists for this program will be **Neil Schlackman, M.D.**, medical director and vice president of medical delivery for U.S. Healthcare, and **Michael Tanner**, director of health and welfare studies with the Cato Institute in Washington, D.C.

Schlackman

Tanner

Dr. Schlackman is a Philadelphia native who received his M.D. degree from Hahnemann Medical College in 1968. He completed his internship and residency, and also a fellowship in pediatric-hematology at St. Christopher's Hospital for Children.

A major in the U.S. Air Force, Dr. Schlackman was a pediatric hematologist-oncologist at David Grant Medical Center at Travis AFB from 1971-73, during which time he was also a clinical instructor of pediatrics at the the University of California at Davis. In 1973, Dr. Schlackman returned to Pennsylvania to open his private practice in Sellersville and become a clinical associate professor of pediatrics at the Temple University School of Medicine, a post he still holds today.

In 1986, Dr. Schlackman became associate medical director of U.S. Healthcare, a company which operates managed care programs in six states. He then left private practice the following year when he was promoted to his current position as medical director and vice president for U.S. Healthcare.

Mr. Tanner served as director of research for the Georgia Public Policy Foundation in Atlanta before accepting his present role as director of health and welfare studies with the Cato Institute in Washington, D.C. During his career, Mr. Tanner also spent five years as legislative director with the American Legislative Exchange Council, where he specialized in health and welfare issues.

An adjunct scholar with The Mackinac Institute in Michigan and the Alabama Family Alliance, Mr. Tanner is a contributing editor to *Intellectual Ammunition* magazine. He is the author of five books on health care reform and is the author of *Children, Family, Neighborhood, Community: An Empowerment Agenda*, a study of state welfare reform.

The Physician/Public Session will be moderated by WVSMA President Dr. Dennis Burton. For more details about this event or any of the other Mid-Winter Clinical Conference programs, phone Nancie Divvens at (304) 925-0342. A registration form for the meeting is printed on page 485.

Medical College of Virginia offering annual head/neck anatomy course

A four-day course entitled "*The Alton D. Brashear Postgraduate Course in Head and Neck Anatomy*" will be conducted from February 27 - March 2 at the Medical College of Virginia in Richmond.

Lectures and demonstrations will augment the laboratory work. This course is approved for 44 credit hours in Category 1 of the Physician's Recognition Award of the AMA and the Academy of General Dentistry.

More information can be obtained from Dr. Hugo R. Seibel, Department of Anatomy, P.O. Box 980709, Medical College of Virginia, Richmond, VA 23298-0709.

University of Oklahoma sponsoring 22nd critical care conference

The University of Oklahoma's 22nd Annual Critical Care Medicine Course will take place from March 4-9 at the Marriott Hotel in Oklahoma City, Okla.

The 48 CME credit hours offered at this meeting are acceptable by the AMA, AAFP, AOA and ACEP.

Course Coordinator Dora Lee Smith can be contacted at (405) 271-5904 for additional details.

Electronic patient records meeting to take place in Orlando in March

The Medical Records Institute has announced plans for "*Toward an Electronic Patient Record '95: Eleventh International Symposium on the Creation of Electronic Health Record Systems and Global Conference on Patient Cards,*" which will be presented at Disney's Contemporary Resort in Orlando, Fla., from March 14-19.

More than 80 companies will be exhibiting a variety of electronic health record systems and products at the meeting.

Phone the Medical Records Institute at (617) 964-3923 for more information.

Seattle site for national Children's Defense Fund annual seminar

The Children's Defense Fund's 1995 Annual National Conference - - *Leave No Child Behind: Building and Strengthening Communities for Children* will be held March 9-11 at the Washington State Convention and Trade Center.

Phone the CDF at (202) 662-3684 for details.

MOVING??

If you are a WVSMA member who will be changing your office or home address, please phone WVSMA Membership Coordinator Donna Webb at (304) 925-0342 as soon as possible so your *Journal* and other WVSMA mailings will not be disrupted.

All other *Journal* subscribers who have address changes should phone WVSMA Advertising Manager Michelle Ellison at this same number.

Prescribing Prevention

U.S. Surgeon General Dr. Jocelyn Elders received many standing ovations during her keynote address for the First International Conference on Prevention, which was presented in Charleston from October 27-30. In her speech, Dr. Elders discussed the need to strengthen the nation's public health system by focusing more emphasis on *"the three P's -- Poverty, Population and Prevention."*

CME symposium scheduled for CLIA '88 laboratory directors

The National Laboratory Training Network, Southeastern Office is sponsoring a program entitled "*Symposium for CLIA '88 Laboratory Directors*" from March 9-11 at Wild Dunes, S.C.

The director for this course will be Tina Stull, M.D., of the Centers for Disease Control and Prevention. A total of 13 CME units are being offered for the core curriculum and another 11 CME units are being offered for optional courses.

For further details, phone the National Laboratory Training Network at (800) 536-6586 (Southeast only) or (615) 262-6315.

Legislative Briefing, Reception set

The 1995 WVSMA Legislative Briefing and Reception has been scheduled for Wednesday, February 8 at the Charleston Marriott.

The briefing will begin at 5 p.m. and the reception will follow at 6:30 p.m. The WVSMA lobbyists will again be updating members on legislation the WVSMA has introduced and supported. Currently, the WVSMA Legislative Committee is preparing its legislative package which will include the Medical Savings Account proposal introduced last year, tort reform, and the Patient Protection Act.

Please mark your calendars now and plan to attend these two important events. More details will be provided in future issues of the *Journal* and *WESGRAM*.

The Excitement is Snowballing...

Join us for the 1995 Mid-Winter Seminars and Scientific Conferences

January 19-22, 1995
Radisson Hotel - Huntington

The WVSMA's Mid-Winter Sessions will be held in conjunction with the Fourth Annual Scientific Meeting of the West Virginia Chapter of the American College of Physicians. Call the WVSMA at (304) 925-0342 for more information.

1995 Mid-Winter Registration Form

Name _____

Phone _____

Address _____

City _____ State ____ Zip Code_____

Payment by:____ Check ____ Visa ____ MasterCard

Card Number _____

Expiration Date _____

Signature _____

If paying by check, please send registration form and check to:

West Virginia State Medical Association
P.O. Box 4106
Charleston, WV 25364
(304) 925-0342

Conference Cost:	WVSMA member	$125	_____
	non-member	$175	_____
Lunch & Learn	Physician	$50	_____
	spouse/student	$35	_____
	TOTAL		_____

Conomikes — **Thursday, January 19**

9 a.m. - noon "Reception and Patient Flow Techniques" (Lunch on your own)

1 - 4 p.m. "Better Collections, Billing and Insurance Methods"

morning only	$95	_____
afternoon only	$95	_____
both sessions	$185	_____
TOTAL		_____

Continuing Medical Education

Listed on this page are some of the upcoming CME programs which will be held in the state. Unless otherwise noted, the events are presented at the location under which they appear.

If you would like to have the CME programs offered by your institution or association for physicians printed in the *Journal* or obtain more details about the meetings listed, please contact Nancy Hill, managing editor, at 925-0342.

Cabell County Medical Society - Huntington

January 12
"Recognizing and Treating Depression," Jeff Kelsey, M.D., Gateway Holiday Inn, 6:30 p.m.

Robert C. Byrd Health Sciences Center of WVU - Charleston

December 1
(Teleconference) "LDLs and You," Shawn Chillag, M.D., noon

December 15
(Teleconference) "Medical Evaluation of Sexually Abused Children," Kathleen V. Previll, M.D., noon

West Virginia State Medical Association - Charleston

January 19-22
WVSMA's Mid-Winter Clinical Conference, Radisson Hotel, Huntington

Outreach Programs

Key to Sponsors

★ *Robert C. Byrd Health Sciences Center of WVU, Morgantown*

☐ *CAMC/Robert C. Byrd Health Sciences Center of WVU, Charleston*

Gassaway ☐ Braxton County Memorial Hospital, Dec. 5, 6:30 p.m., "Lung Carcinoma," Rakesh Wahi, M.D.

Logan ☐ Logan General Hospital, Dec. 9, 11:45 a.m., "Gestational Diabetes in Pregnancy," David Chaffin, M.D.

Montgomery ☐ Montgomery General Hospital, Dec. 7, TBA*

New Martinsville ★ Wetzel County Hospital, Dec. 8, noon, "Laboratory Tests in the Diagnosis of Rheumatologic Diseases," Jo Ann Allen, M.D.

Parkersburg ★ Camden-Clark Memorial Hospital, Dec. 7, 7:30 a.m., "Dystonia: What Is It and How Do You Treat It?" Laurie Gutmann, M.D.

★ Camden-Clark Memorial Hospital, Dec. 14, 7:30 a.m., "Estrogens: Risks and Benefits," Mark Gibson, M.D.

Richwood ☐ Richwood Area Medical Center, Dec. 8, 5:15 p.m., "Cancer Prevention Screening," Arvind Kamthan, M.D.

Ripley ☐ Jackson General Hospital, Dec. 9, TBA*

Spencer ☐ Roane General Hospital, Dec. 20, TBA*

White Sulphur Springs ★
The Greenbrier Clinic, Nov. 28, 4 p.m., "Disability Rating: Contemporary Issues in West Virginia Practice," Janie Vale, M.D., M.S.P.H.

** To be announced*

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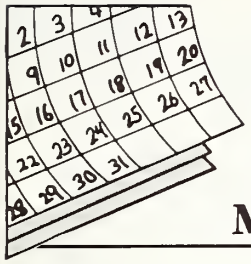


Medical Meetings

December

2–The 80th Scientific Assembly and Annual Meeting of the Radiological Society of North America, Chicago

8-9–Tools and Techniques for Improving Clinical Outcomes: A Practical Seminar for Physicians and Clinical Leaders (sponsored by the Joint Commission on Accreditation of Healthcare Organizations), Cincinnati

8-10–National Conference on Community Development (sponsored by the National Rural Health Association), Minneapolis, Minn.

10–The Eleventh Annual Clinical Update in Pulmonary Medicine (sponsored by the Deborah Heart and Lung Center), Atlantic City, N.J.

10-15–American Academy of Facial Plastic and Reconstructive Surgery, Key Biscayne, Fla.

January

20-21–Clinical Innovations in OB/GYN Ultrasound (sponsored by Meetings & Management Techniques Plus), San Antonio, Texas

27–The Ethics and Law in West Virginia of Health Care Decision Making for Incapacitated Patients (sponsored by the West Virginia Network of Ethics Committees), Flatwoods, W.Va.

February

5-8–Southern Surgical Congress, New Orleans

6-8–Cardiovascular Conference at Snowshoe (sponsored by the American College of Cardiology), Snowshoe, W.Va.

9-12–50th Annual Postgraduate Ob/Gyn Assembly (sponsored by the Ob/Gyn Assembly of Southern California), Beverly Hills, Calif.

11-18–Super EMG XVI (sponsored by Ohio State University), Kohala Coast, Hawaii

16-19–American Academy of Pain Medicine, Palm Springs, Calif.

16-21–American Academy of Orthopaedic Surgeons, Orlando, Fla.

20-22–Cardiopulmonary Rehabilitation Symposium: Status '95 (sponsored by the University of Florida), Orlando, Fla.

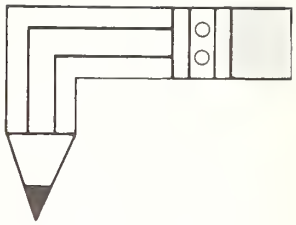
February 24-March 1–American Academy of Allergy and Immunology, New York City

February 27–March 2–The Alton D. Brashear Postgraduate Course in Head and Neck Anatomy (sponsored by Virginia Commonwealth University), Richmond

For More Information . . .

Contact the Journal at (304) 925-0342.

Poetry Corner



Just Memories

You left memories
Of kind footprints
On my heart.
Your tread was light
And I thought that I might
Overcome my feelings from the start,
But you left memories
Of kind footprints
On my heart.

You left memories
Of your laughter
In my mind.
We laughed a lot
And I thought
Your image would fade in time,
But you left memories
Of your laughter in my mind.

You left memories
Of your goodness
On my soul.
Before you came
I was crippled and lame,
Half a man, and you made me whole.
You left memories
Of your goodness
On my soul.

You left memories
Of your love
Wherever I go.
I can't forget
Your love, but yet
Memories are all I'll ever know.
You left memories
Of your love
Wherever I go.

Robert L. Smith, M.D.

Please address your submissions for Poetry Corner to Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

Department of Health & Human Resources

Bureau of Public Health News

This page of material is submitted and paid for by the Bureau of Public Health.

Health commissioner wins national award

William T. Wallace Jr., M.D., M.P.H., the state health commissioner, was presented the McCormack Award during the 1994 annual meeting of the Association of State and Territorial Health Officials (ASTHO) in St. Louis, Mo., in recognition of his contributions to the public health field

Dr. Wallace has more than 30 years experience in public health, beginning with his career in the U.S. Public Health Service, Division of Indian Health at Hastings Hospital in Tahlequah, Okla. He spent nearly 10 years in the African republic of Liberia, first performing missionary work and then serving as a county public health officer and a director of medical services with the republic's Ministry of Health and Social Welfare. Since 1990, he has served as the public health commissioner in West Virginia, and prior to this, he held the position of director of public health in New Hampshire for 10 years.

Dr. Wallace's nomination for the award cited his dedication to public health, his strong leadership skills and support for his staff, and his belief in "people before programs."

WVPHA honors two officials, tobacco control coalition

Public health professionals Dr. James H. Walker and John Cooper, R.S., and the West Virginia Tobacco Control Coalition were among the honorees during the 70th annual meeting of the West Virginia Public Health Association.

Dr. Walker, of Charleston, was inducted into the WVPHA's Hall of Fame for his dedication to public health for more than 40 years. He currently serves as medical director for the West Virginia Bureau of Public Health's Handicapped Children's Program and Tuberculosis Control Program. Dr. Walker began his career as a leader in cardiac research and care, performing the first open heart surgery in the state in 1960. His work with handicapped children and tuberculosis patients has brought great insights and innovations to both fields.

Cooper, local administrator of the Jefferson County Health Department, received the WVPHA's Public Health Merit Award. He began his career 40 years ago with the Tri-County Health Department serving Jefferson, Berkeley and Morgan counties and he has received numerous awards over the years for his contributions as a public health sanitarian.

The West Virginia Tobacco Control Coalition received the Public Health Merit Organization Award, as well as the Health Education and Training Section Award for Health Promotion. The WVTCC was formed in 1988 and currently has more than 50 members statewide, dedicated to promoting healthier lives by reducing tobacco use and its consequences, including secondhand smoke.

Over the past two years, the WVTCC was helpful in working with boards of health to get clean indoor air regulations passed in 10 counties. The coalition supports legislation for state and local clean indoor air laws and for laws to prevent youth access to tobacco.

New law requires insurance coverage of immunizations

West Virginia physicians need to be aware that a new state law mandates insurance companies operating in the state to pay for all immunization services for children age 16 and younger.

Effective July 1, House Bill 4516 requires that insurance policies provide for the costs of vaccine and vaccine administration if these expenses are incurred by the health care provider. All health insurance policies are required to pay for these services whether or not the policy holder's deductible has been met.

In addition, under the new law health care providers are required to provide parents of newborns and preschool-age children with details about diphtheria, polio, mumps, measles, rubella, tetanus, hepatitis b, haemophilus influenza b and pertussis (whooping cough) and free immunization services for children.

For more information about the new law or about immunization services in West Virginia, call the Bureau's Immunization Program at (304) 558-2188 or 1-800-642-3634.

Satellite course on immunization to be offered this winter

The National Immunization Program is offering the first live, interactive satellite teleconference course in conjunction with the U.S. Centers for Disease Control and Prevention, the University of North Carolina at Chapel Hill and the North Carolina State Health Department.

The course will consist of four 3-hour modules concentrating on the epidemiology of vaccine-preventable diseases and practical information on the use of vaccines. The modules are scheduled for January 19, February 2 and 16, and March 2. Each session will air from noon until approximately 3 or 3:30 p.m.

There is no fee to participate and the course is open to physicians, nurses, clinic staff and other health care providers. A total of 12 CME (Category I of AMA) or 1.5 CEU credits will be available.

If you are interested in taking part in the course or would like more information, call Savolia Ellis of the Bureau's Immunization Program at (304) 558-2188 or 1-800-642-3634. Ms. Ellis must hear from you as soon as possible in order to determine the number and location of the downlink sites needed, as well as to complete the course enrollment procedures. In addition, a registration form appears in the November 15 issue of the WVSMA's newsletter, *WESGRAM.*

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ROBERT C. BYRD HEALTH SCIENCES CENTER OF WEST VIRGINIA UNIVERSITY

Compiled from material furnished by the Robert C. Byrd Health Sciences Center of West Virginia University, Communications Division, Morgantown

Center on Aging established at HSC

Biddington

A Center on Aging has been created at the HSC to coordinate and expand WVU's services to the state's older citizens.

This new center will act as a resource for experts in aging throughout WVU, according to W. Robert Biddington, D.D.S., associate vice president for health sciences and interim director of the new unit. "There are unique unique challenges and opportunities associated with aging in rural Appalachia."

The center will bring together several efforts, including the 65-Plus Clinic in the Physician Office Center; educational programs for undergraduate students and graduates in the health and social services professions who work with the elderly; and research programs focused on ailments affecting older people. Drs. Richard Layne, Marilyn Jarvis-Eckert, and Robert Keefover will serve as the center's three associate professors.

Major research efforts are being directed at Alzheimer's disease and similar disorders. The opening of the state-of-the-art Positron Emission Tomography facility will substantly enhance research in brain disease, such as Alzheimer's dementia.

Charleston Division names ob/gyn chair

Dr. E. Reed Heywood has been appointed chair of the Department of Obstetrics and Gynecology at WVU's Charleston Division.

Dr. Heywood is a graduate of the Utah College of Medicine who has been a faculty member in academic medicine for 22 years. He has interests in infertility surgery and education administration.

Eye Center receives grant from WV Lions

The University Eye Center is purchasing new computerized vision testing equipment thanks to a $31,000 grant from the West Virginia Lions Sight Conservation Foundation. This equipment will be part of the newly named West Virginia Lions Visual Function Laboratory, which will provide comprehensive testing for the diagnosis and treatment of eye disease.

A full range of electrophysical tests useful for diagnosing and managing many common eye disorders, such as glaucoma and diabetic retinopathy, can be conducted with this new equipment. Other tests available can help diagnose inherited eye disease in young children, indicating whether the disease is stable or progressive, and alerting families that other family members may have the same disease. In addition, patients with cataracts can get an accurate prediction of how well they will be able to see after surgery.

A previous donation from the Lions in 1991 funded the construction of the Lions Clinical Research Unit, which houses the new laboratory.

Bone marrow project celebrates 2nd year

The Bone Marrow Transplant Program at the Mary Babb Randolph Cancer Center celebrated its second anniversary on October 14.

Since the clinic was opened on October 14, 1992, 116 bone marrow transplants have been performed at the center, which is the only facility in West Virginia for these procedures.

Visiting Physicians Program created

The Department of Family Medicine, in conjunction with the Department of Medicine, has implemented a Visiting Physicians Program.

This program gives selected internists and family practitioners the opportunity to visit the HSC and spend a half a day in a learning rotation.

Omert named trauma chief, center director

Omert

Dr. Laurel Omert, assistant professor of surgery, has been appointed chief of the Section of Trauma in the Department of Surgery and director of the Jon Michael Moore Trauma Center.

Dr. Omert has been serving in these two positions in an interim capacity since January.

CAMC Foundation assisting MDTV

The Charleston Area Medical Center Foundation has awarded a $498,000 grant to support Mountaineer Doctor Television (MDTV).

The grant, directed to CAMC's Continuing Education unit, will enable CAMC to purchase the equipment to connect three sites in Charleston to the MDTV system. Health care professionals at each of the sites will have full communications capability with all of the hospitals on the MDTV network.

Toffle appointed ob/gyn vice chair

Dr. Roger Toffle, associate professor, has been named vice chair of the Department of Obstetrics and Gynecology.

Dr. Toffle is also director of the Department of Obstetrics and Gynecology's Reproductive Endocrinology/Fertility Division.

Brancazio receives best ob paper award

Dr. Leo Brancazio, assistant professor of obstetrics and gynecology, received the award for the best paper at a recent meeting of the Society of Obstetric Medicine.

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West Virginia is ranked third in the nation for smoking and first in the nation for smokeless tobacco use. The West Virginia Tobacco Control Coalition supports three statewide policy measures to reduce tobacco use and its effects. Help improve the health of West Virginians by advocating for these pieces of legislation:

Statewide Clean Indoor Air would restrict smoking in designated public places and work sites. Protects nonsmoking citizens and provides a supportive environment for those who want to quit.

Youth Access Prevention would require retailers to be licensed to sell tobacco products to hold them more accountable to current law that prohibits sales to people under 18. Prohibits free sampling or coupon distribution and requires lock-out devices for vending machines.

Tobacco Excise Tax would increase the excise tax on cigarettes and impose the first tax on smokeless tobacco. Studies show that as the price increases, smoking rates decline - especially among youth.

WEST VIRGINIA
TOBACCO CONTROL COALITION

The West Virginia Tobacco Control Coalition is made up of 50 member organizations, including the American Lung Association of West Virginia, the American Cancer Society, West Virginia Division, Inc. and the American Heart Association of West Virginia.

Marshall University School of Medicine

MARSHALL UNIVERSITY

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington

Med School to send medical team to Venezuela

They may live a primitive lifestyle, but the Yanomami Indians in southeastern Venezuela desperately need modern medicine to combat the diseases that are attacking them.

Next month the Marshall University School of Medicine will come to their aid.

Dr. John Walden will lead an emergency medical team on the first of a three-phase program to help the Yanomami help themselves.

"These are, by far, the least acculturated tribesmen in the world," said Walden, who is a tropical medical specialist, associate dean and chief architect of the plan.

Malaria, hepatitis B, river blindness and, most recently, tuberculosis are plaguing the Yanomami, a 15,000-member tribe living along the Orinoco River.

Walden plans first to scout out the geography for potential airstrips and to bring a few vaccines. In January, a larger team will bring more medicines. In the third phase, he and others will train the indigenous people in the ways of modern medicine so they can return to their remote villages to treat others.

"Most have no access to health care," Walden said. "And they have no way of defending themselves without modern medicine."

Walden, a veteran of 70 trips into the jungle, has orchestrated a multifaceted project. He is working with the Amazonia Foundation, the Healthcare Foundation of the United Kingdom and Virgin Atlantic Airways.

The last has been raising money for his efforts and its chairman plans to accompany Walden on the January trip.

Walden also is working with several Venezuelan organizations, including a group of physician providers.

"It's the pleasure of my life," Walden said about his nearly three decades of working in remote areas of Central and South America.

"I like the jungle and the Indians. I take pleasure in their company."

Walden, 51, must totally rely on their survival skills when he travels there. He speaks some of their ancient language but most often uses his Spanish and Portuguese with native guides.

The patriarchal Yanomami hunt with bows, arrows, spears and clubs and raise some food by farming. They wear only loincloths and they sleep in hammocks in large, circular buildings called shabanos.

"The Indians are remarkable," Walden said."They have managed to remain so isolated."

But why involve medical students in so remote a culture?

For many reasons, Walden said.

Physicians need to be sensitive to cross-cultural concepts, he said.

This is one of the many Indian families Dr. John Walden has cared for during his trips to Central and South America over the past 25 years. Dr. Walden says working in Third World regions gives medical students and physicians new perspectives on health and sickness, life and death.

"As they learn about cost-containment, what better way to appreciate it than in a situation where you literally have to watch every penny," he said.

Walden said such experiences also help students learn when to prolong life and when not to.

"There comes a time for all of us to let go," he said. "You find yourself able to do that in a better fashion when we have these experiences overseas."

The Yanomami, perhaps the most remote and unacculturated tribe left on earth, are another step for Marshall medical students.

Already, Walden said, the school has sent students to 23 countries across the globe.

"After one trip, they feel energized," Walden said. "They're ready to go back into what they are training for."

(Reprinted with permission from the Charleston Daily Mail)

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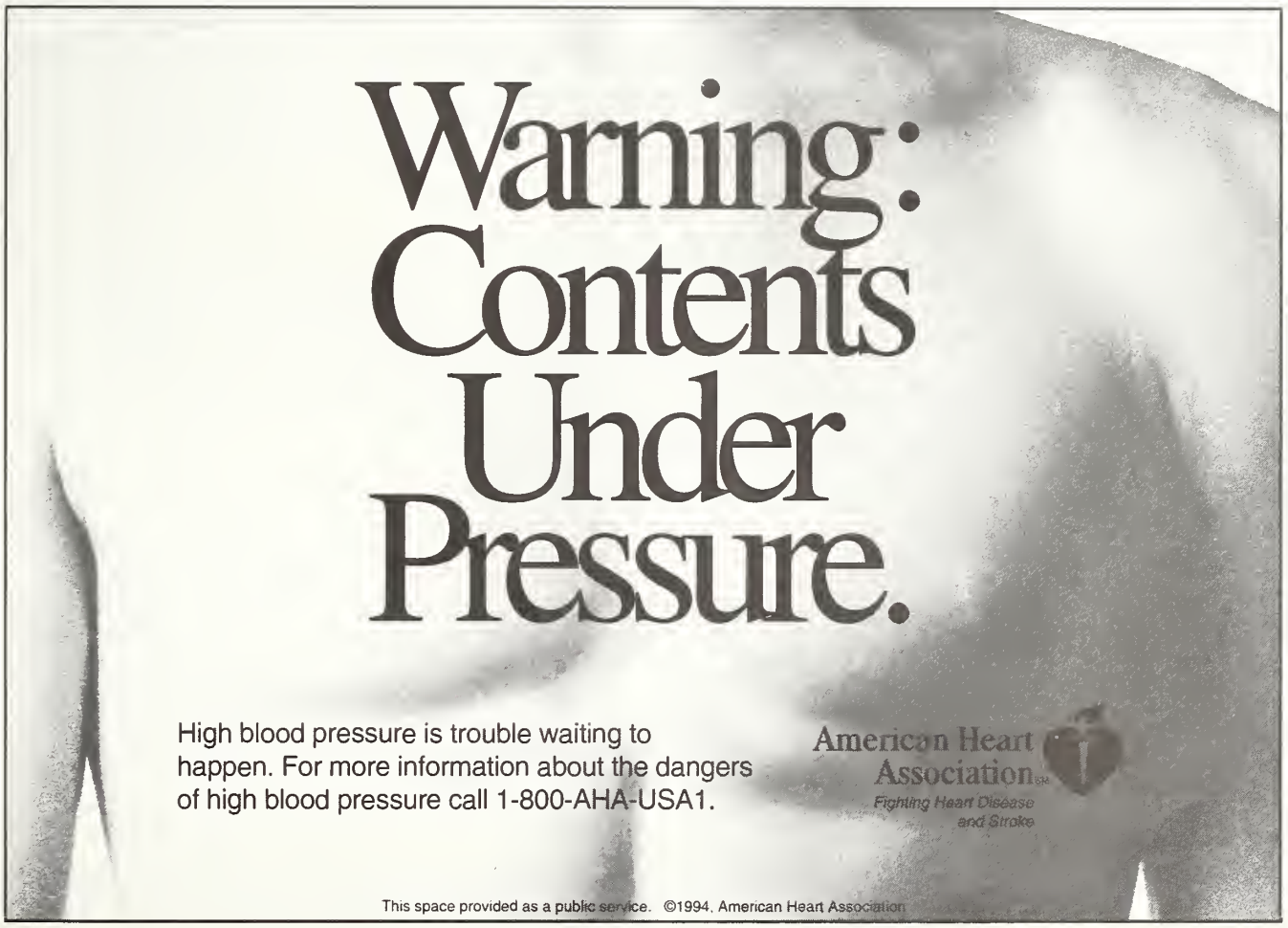

Several changes proposed for MSS bylaws

Editor's Note: *The following sections in bold type are the proposed changes to the bylaws for the WVSMA's Medical Student Section. In accordance with the MSS's Constitution and Bylaws, any proposed amendments must be published in the West Virginia Medical Journal 30 days in advance of the MSS's Annual Business Meeting. This year's meeting will take place on Saturday, January 21 at the Radisson Hotel in Huntington during the WVSMA's Mid-Winter Clinical Conference. If you have any questions about these proposed changes, contact WVSMA Membership Coordinator Donna Webb at (304) 925-0342*

CHAPTER II. OFFICERS

Section 1. The officers shall be President, Vice President, and Secretary/Treasurer who shall serve one year terms. Nominations for officers will be accepted from any active member of the Section at the Annual MSS meeting to be held in the month of January. **"A nominee may be any active member from a component student medical society. A curriculum vitae and personal statement are required to be provided by a nominee at the time of the nominations." Nominations may be made in the form of either voice nomination during the business meeting or as a letter of nomination signed by two active members accompanying the nominee's curriculum vitae and personal statement. Personal statements may be made in writing or by speech during the Annual Meeting. Within two weeks following the Annual Meeting a ballot will be mailed to all active members. Each member will then have 14 days to return their ballot to the WVSMA office. Ballots will be signed to validate the member's status. The Executive Council and/or an appointed Election Committee will then meet to tally the votes."** In the event of a tie, the President shall cast the deciding vote. If so elected, a Councilor must relinquish his/her seat as Councilor.

CHAPTER III. DELEGATES

Section 1. The President during his or her term of office shall serve as the Delegate to the WVSMA Annual Meeting. The Vice President shall serve during his or her term of office as the Alternate Delegate to the WVSMA Annual Meeting. The President may appoint the Secretary/Treasurer to serve as the Alternate Delegate to the WVSMA Annual Meeting if the Vice President is unable to serve. If the Vice President or the Secretary/Treasurer is unable to serve as Alternate Delegate, the President may appoint a Councilor. **"Likewise, if the President is unable to serve as Delegate, then the Vice President shall serve as the Delegate and Alternate Delegate shall be the Secretary/Treasurer."**

Section 2. **"The delegates to the AMA National Meeting shall be the President of the Executive Council who shall represent his or her component society, the Vice President of the Executive Council who shall represent his or her component society, the Secretary/Treasurer of the Executive Council who shall represent his or her component society. In the event that the Vice President and the President are from the same component society, the Vice President shall serve as the Alternate Delegate from his or her component society. In the event that the Secretary/Treasurer is from the same component society as the President or Vice President, the Secretary/Treasurer shall serve as the Alternate Delegate from his or her component society. In the event that all three officers of the Executive Council are from the same component society, the President shall serve as the Delegate from the component society and the Vice President shall serve as the Alternate Delegate from the component society."**

Section 3. **"Each component society shall have at least two representatives. If a component society is represented by only one member within the Executive Council, the Alternate Delegate shall be the President of the Component Society. If the component society is represented by two members within the Executive Council, the representative positions will have been fulfilled and said component society shall not chose any further Delegates or Alternate Delegates. If a component society is not represented within the Executive Council, the Delegate shall be the President of the component society and the Alternate Delegate shall be the Vice President of the component society."**

Section 4. **"If the Delegate or Alternate Delegate, as determined by the preceding sections is unable to fulfill his or her duties, the Executive Council shall appoint a representative from the same component society of said Delegate or Alternate Delegate to fulfill the term of the Delegate or Alternate Delegate who is unable to fulfill his or her duties."**

New Members

We would like to welcome the following new members to the WVSMA:

Physicians

David G. Chaffin, MD
830 Pennsylvania Avenue
Charleston, WV 25302

David E. Hess, MD
109 Doctor's Drive
Bridgeport, WV 26301

Jack Traylor, MD
2561 3rd Avenue
Huntington, WV 25701

Andrew Berens, MD
RR 2, Box 78D
Berkeley Springs, WV 25411

Murshid A. Latif, MD
Rt. 4, Box 9A
Physician's Building I
Weston, WV 26452

Omayma T. Touma, MD
191 Camelot Drive
Huntington, WV 25701

Juan M. Limjoco, MD
2900 First Avenue
Huntington, WV 25702

M.A. Ghannam, MD
601 Chestnut Street
Charleston, WV 25309

Amando Medina, MD
918 Chestnut Ridge Road
Morgantown, WV 26505

Imran T. Khawaja, MD
1801 6th Avenue
Huntington, WV 25702

Resident Physicians

Walid H. Azzo, MD
Bluefield, WV

Ginamarie Foglia, MD
Morgantown, WV

Joohyong Kim, MD
Morgantown, WV

Kwangsup Sheen, MD
Wheeling, WV

Kimberly Burgess, MD
Huntington, WV

Salam Rajjoub, MD
Wheeling, WV

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Wheeling, WV

WESPAC Members

We would like to thank the following physicians and Alliance members for their contributions to WESPAC:

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Ramah Jones

Sustainer Members

Central
Anne Ramirez

Harrison
Sue Bryant

Obituary

Robert W. Coplin, M.D.

Dr. Robert W. Coplin, 81, of Ellizabeth, died September 30 at the Coronary Care Unit of Camden-Clark Memorial Hospital after a brief illness.

Dr. Coplin was born in Zacksville, W.Va., and attended Wirt County schools and Morris Harvey College in Charleston. He received a bachelor of science degree in 1935 from West Virginia University, and his M.D. degree from the University of Louisville, where he specialized in gynecology and surgery.

After an internship at St. Marys Hospital in Huntington, Dr. Coplin established a practice at the Rowley Clinic in Huntington. He returned to Wirt County in 1947 to take over his father's practice and he built the Coplin Clinic in Elizabeth. His private practice continued after the hospital division of the Coplin Clinic closed in 1960. Under his leadership, the clinic became the Coplin Memorial Community Health Center, where he served as senior medical advisor. Dr. Coplin was also instrumental in building Roane General Hospital in Spencer, where he served on the medical staff.

During his career, Dr. Coplin served for many years as the Wirt County Health Officer and continued conducting clinics for the Health Department even after he retired in 1981. He served as medical director for the Wirt County Emergency Services and often instructed classes for emergency medical technicians. He was the first medical examiner of Wirt County and helped coordinate the county's first bloodmobile.

Active in the Wirt County schools and in the Elizabeth communty, Dr. Coplin conducted free sports clinics and served as team physician for many years. He was also honored for his years of service as team physician for the Wirt County Pee Wee/Pop Warner football program. In addition, he served more than eight years on the Elizabeth Town Council and was on the board of directors of the Wirt County Bank.

In 1991, Dr. Coplin was the first member of the WVSMA to receive the WVSMA's Rural Physician Award for his years of dedication to rural health care. He was also the recipient of the Community Service Award by the Church of the Nazarene in 1988, and he was honored by Camden-Clark Memorial Hospital in 1985 for 36 years of outstanding medical service.

A commissioned officer in the U.S. Army medical corps during World War II, Dr. Coplin served in both the European and Pacific theaters and Panama. In addition to being a member of the WVSMA, Dr. Coplin was also a member of the AMA; the Elizabeth Baptist Church; the Elizabeth Lions Club; the Cabell Lodge 152, AF & AM; Scottish Rite of Charleston; Huntington Chapter 6, RAM; Beni Kedem Temple of the Shrine; BPOE 198 of Parkersburg; and an admiral of the Cherry River Navy.

Surviving are his two sons, Richard Coplin of Elizabeth and Jay Coplin of Charleston; his daughter, Dinah Law of Wheeling; and a grandson. He was preceded in death by his wife, Mildred "Mim" Pettit Coplin; and two brothers, Rolla W. Coplin and Harry W. Coplin.

Memorials are preferred to County Senior Citizens, Elizabeth Baptist Church, or the Wirt County High School Athletic Boosters.

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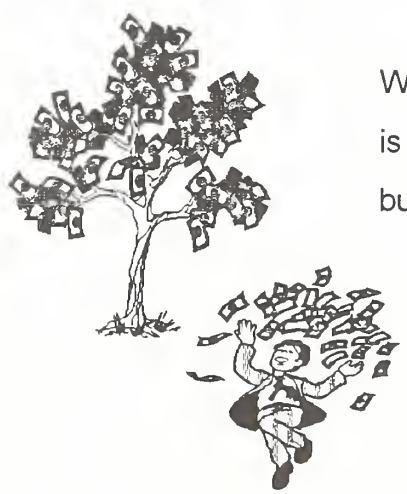

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Front Cover

This year's Christmas tree at the State Capitol in Charleston creates a festive holiday scene. Photo courtesy of *Robbie Parsons* of South Charleston.

Dr. Henry M. Hills Jr.: Our own hero of the Battle of the Bulge

Editor's Note: Dr. Hills is an orthopedic surgeon in Charleston who has been a member of the WVSMA and the Kanawha County Medical Society since 1941. His heroic actions during World War II were recently documented in a special manuscript by Dr. Michael Fidler, who is also a Charleston orthopedic surgeon. This article is compiled from exerpts in Dr. Fidler's interview with Dr. Hills and his wife, Willie. In conjunction with this article, an editorial about the Battle of the Bulge appears on page 521.

At the WVSMA's Annual Meeting at The Greenbrier in August, Dr. Henry Hills and Dr. Michael Fidler proudly stand with the exhibit which Dr. Fidler created to honor Dr. Hills and the other Army doctors and surgical technicians who flew across enemy lines in a glider to care for soldiers at the Battle of the Bulge. This display won the Southern Medical Association Auxiliary's Medical Heritage Award for the Best County Exhibit in its class.

In 1941 at the start of WWII, Dr. Henry M. Hills Jr. had been in practice in Charleston with orthopedic surgeon Dr. Randolph Anderson, and he had gone to Boston for further orthopedic training at Massachusetts General Hospital. He and his wife, Willie, a nurse, had been married for three years and she was teaching home nursing courses and working in Boston at the Joslin Clinic.

Since he had enlisted, it wasn't long before Dr. Hills was called to duty and he was assigned to Walter Reed Army Hospital in Washington, D.C., for training. Before he was sent overseas to the 12th Evac Hospital, Dr. Hills went on maneuvers in Tennessee and at a camp near Boston.

It was a tearful day when Dr. Hills had to leave for England and leave his beloved Willie, who was pregnant at the time with their son. Little did they know it would be three and a half years before they would see each other again.

When he arrived in England, Dr. Hills spent 18 months taking care of the 8th Air Force in their bombing runs over France and Germany.

"We worked like hell," Dr. Hills remembered. "We had a big clinic. The most notorious thing was the '3B fracture' - - Beer, Blackout and Bicycle - - they all broke their radial heads. Then, just before the invasion, we were put in Patton's army, the 3rd Army. The first directive we got was "If you do not take the objective and are not killed or mortally wounded in the attempt, you will be court-martialed."

On D-Day, Dr. Hills and the 3rd Army were set up in a hospital on the English coast to receive patients from the invasion. The 3rd Army was made up of two tank divisions for every infantry division. According to Dr. Hills, "one division would punch a hole, then the tanks would go up and down the line and tear the enemy to pieces. The Germans were scared to death of General Patton and they needed to be. We had a terrible striking force," he added.

They were at their beachhead for about two weeks, and during this time Dr. Hills had his first meeting with General Patton.

"Patton was a great fellow," Dr. Hills commented. "He came into the clinic to have his nose treated. He had a cold and stopped up nose, and the colonels came around and fawned over him. He turned around and said 'What's the matter with these people? I can't do anything to help them." (Patton was criticizing the colonels for making over him so much, as well as referring to the fact that it was a "typical New York outfit because the city guys would knife you to get ahead of you," Dr. Hills said.)

After leaving the beaches of Normandy, Dr. Hills and his unit moved constantly with the front so they could operate hospitals as needed. His typical day would consist of a 12-hour shift in surgery where he would usually operate on 20-40 patients. Then, he would check on his

patients and go over charts for about eight hours before grabbing four or five hours sleep. This cycle soon took its toll on Dr. Hills.

"There were a lot of severe wounds such as hip wounds and so forth," Dr. Hills recalled. "And that's when I lost my cool.

"We were in Luxembourg in a hospital building and I had a Luxembourger who was to help around my surgery unit. He didn't know any English at all, and I didn't know his language. At that time I was working real hard, there would be 20 or 30 lined up whenever I came on duty. I'd get them done and think, 'Good, next time I come there won't be so many.

"Well, next time there would be 20 or 30 or 40. So, I'd get to the point where things would happen, like I would be in a hip and a bleeder would get loose, and I'd utter a swear word or two and I'd clamp the damn thing. Then, it would come loose again, so I would clamp it and tie it again and it would start to come loose. I'd utter some special words, and I finally got to where I was even throwing some instruments, getting kind of wild. I made up my mind I wasn't going to say another word, wasn't going to do a thing, no matter what happened.

"Well, I got into a hip again, and a gluteal vessel came loose. I had a hell of a time with it, but I didn't say anything. But, I picked up an instrument and I threw it down, and this Luxembourger says, "Gott dammit!"

About two weeks later, Dr. Hills and the 12 Evac Hospital unit went to Nancy, where they came under attack from the long German siege guns.

"The Germans shelled our hospital and a 750 pound shell was buried 20 feet in the ground right below our unit, right at the corner of our hospital in the orthopedic ward," Dr. Hills said emphatically. "Fortunately, it didn't go off. The shells would come in regular as time. Just as you'd go off to sleep - - 'WHEEEEEEEE' - - in would come another one. And then they would move the seige gun a little further down the railroad track before anyone could hit it."

While Dr. Hills was in Nancy, the Battle of the Bulge began and a commander asked for volunteers to parachute in to the front by glider to care for about 800 casualties in a garage. He volunteered to go because he said he was "so mad" that there were so many patients at the hospital who were trying to get out of serving.

Dr. Henry Hills and his wife, Willie, celebrated their 56th wedding anniversary this year. The Hills are pictured here at The Greenbrier during the WVSMA's Annual Meeting in August.

On Christmas Day, Dr. Hills was taken to an airstrip with Dr. Edward Zinschlag and two sergeants who had also volunteered. They were the first medical personnel to ever be flown behind enemy lines, and the pilots in the gliders had tommy guns. At the last minute, it was decided that Dr. Hills and the others would not have to parachute in because there were so many supplies that needed to be taken. So, the gliders were loaded up and off they flew on the 100-mile trip.

Even though the gliders were shot at by the Germans and a few bullets went through one of the cabins, they had a smooth landing in a field and no one was injured. As soon as they landed, a GI with long whiskers came out and said, "What the hell are you doing out here? This the outmost outpost of the 101st Airborne. Get the hell in here!"

About that time, rockets starting going off and the group was taken into a shallow area for protection. Then, they were taken two at a time in a jeep as fast as possible so mortars wouldn't get them. When they arrived at the garage, it had only a parachute for a door, and the minute they pulled it aside to walk in they were taken aback by the smell of gas gangrene.

"Here were these creatures, lying on parachute cloths, no lights," Dr. Hills remembered sadly. "Some women from Bastogne were there trying to help, giving them water and so forth, and the men were dying like flies. They'd been there for 10 days with wounds that were now gas gangrene.

"The only light was at the far side, where mechanics did repairs. There was a field stove with coffee brewing in that area and they had four tables set up - - stretchers on sawhorses. They had a great big vat filled with alcohol. After a case, we would dump all our instruments and gloves into the vat. We had no gowns or masks, of course. For the next case, you'd reach into the vat and put your gloves on wet, pick out the instruments you needed, and go to work.

"One man in my group acted as a triage officer. The bottom floor of the garage had 400 serious casualties. The top floor had 400 walking casualities and we didn't bother with them.

"The first night I was there the triage officer came to me and said there was a boy in terrible shape who was not going to survive until morning. We had lost all but six pints of our blood when we landed the glider. He said, 'Let's give him a pint of blood and get his leg off." So, we took him in and did it. He had a fever of 105 degrees and was moribund - - didn't need any anesthesia; he was out, he was dying. The next morning one of the nurses came in and said he wanted to talk to me. He thanked me; he had made it."

While Dr. Hills was caring for these injured men, one of the infantry colonels got perturbed because he was amputating limbs. He came down to see Dr. Hills and said to him, "I understand your taking them off right and left here." Dr. Hill replied, "Yep, those that need to come off." The colonel then said, "Well, I'm not quite sure they do." So, Dr. Hills picked up a limb and handed it to him. He nearly passed out and never said a word.

Dr. Hills was on duty continuously for 50 hours until the U.S. troops were able to break through with supplies and ammunition. After this special mission, Dr. Hills was taken back to Nancy, where he worked until the end of the war. He and the other medical volunteers were awarded the Silver Star for their heroism and bravery which saved hundreds of soldiers lives.

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The treatment of gastroesophageal reflux disease

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Abstract

Gastroesophageal reflux disease (GERD) is a common disorder which may result in esophageal ulcers, erosions, strictures and motility disorders if it is not treated promptly. Physician assessment of risk factors and symptoms is essential for accurate diagnosis and determination of appropriate treatment. Mild cases of GERD can be treated with lifestyle modifications and antacid/alginic acid therapy. Moderate and severe GERD can be treated with histamine-2-receptor antagonists (H2RAs) or omeprazole. The H2RAs require split-dosing, at least twice daily, and higher than peptic ulcer disease treatment doses, while omeprazole 20 to 40 mg may be used. Prokinetic agents and sucralfate have been used as adjunctive treatments, however, conflicting data exist about their efficacy. Maintenance therapy is usually required to avoid disease recurrence; either H2RAs or omeprazole may be prescribed.

Introduction

Gastroesophageal reflux is a motility disorder that leads to an increased dwell time of acid. Many patients experience this retrograde flow of stomach or duodenal contents into the esophagus. In fact, about 36 percent of the population experiences heartburn once a month with up to 7 percent having heartburn daily (1).

Gastroesophageal reflux disease (GERD) is any symptomatic clinical condition or tissue damage that results from episodes of reflux (2). GERD is a common disorder, often treated by the primary care physician in the ambulatory setting. For some patients, GERD is relatively benign and easily treated, however, others may experience severe esophageal tissue damage with potential resultant esophageal ulcers, erosions, strictures and motility disorders (2,3). This article comprehensively reviews the various treatment modalities for GERD and provides a rational approach to therapy selection for physicians.

Pathophysiology

Although the pathophysiology of GERD is still not totally understood, the development of GERD can be mechanical or acid-related.

Gastroesophageal emptying relies on a functioning lower esophageal sphincter (LES) to prevent reflux of gastric contents back into the esophagus. A pressure gradient exists that favors reflux into the esophagus since the stomach has a higher pressure than the esophagus. However, in normal patients, the LES exerts a pressure greater than 12 mmHg over stomach pressure. LES pressures of less than 12 mmHg may result in reflux; in fact, an association exists between LES pressures of less than 5 mmHg and severe GERD, but this relationship does not appear to be linear (3).

In normal patients, the LES spontaneously relaxes to allow food to enter the stomach upon swallowing. In GERD patients, the LES spontaneously relaxes more often and for longer periods of time, resulting in lengthened esophageal exposure to refluxed acid which can lead to mucosal injury (3,4). The greater the exposure time, the more likely irritation or erosion may occur. Causes of increased esophageal exposure to acid can include impaired esophageal peristalsis, hiatal hernia, horizontal body position, and decreased salivation (4-7).

In addition to LES abnormalities, other mechanical and metabolic causes of GERD exist. For example, up to 41 percent of patients with GERD have been shown to have delayed gastric emptying (8). Delayed gastric emptying can lead to distention, increased volume, and increased intra-abdominal pressure, resulting in gastric reflux. Another cause of GERD is hiatal hernias, which can impair esophageal clearance by serving as an acid trap that promotes reflux during relaxation of the LES induced by swallowing (9). Hiatal hernias were once thought to be synonymous with reflux and GERD, but most hiatal hernias are now considered to be anatomical variants.

A third factor which may play a role in the development of GERD is impaired mucosal defense (4). The esophageal mucosa is considered to be less resistant to gastric acid than other types of large molecules (e.g., pepsin) in the GI tract. The primary irritants found in the refluxate are gastric acid and pepsin. However, patients with achlorrhydria can develop esophagitis which is thought to be due to bile acids and other proteolytic enzymes (4).

A final condition that can cause GERD is a non-functioning pyloric sphincter because it allows the reflux of bile acids and proteolytic enzymes into the stomach and subsequently into the esophagus, resulting in local irritation and erosions (3,4).

Table 1: Signs and Symptoms of GERD*

Chest	GI Tract	Throat	Lungs	Misc.
Heartburn	Bloating	Hypersalivation	Aspiration	GI blood loss
Regurgitation	Early satiety	Hoarseness	Asthma	Hiccups
Dysphagia	Nausea	Lump in throat		
Odynophagia	Belching			
Chest Pain				

*Adapted with permission from reference 19

Clinical presentation

Risk factor assessment and a thorough medical history (including medication use, symptom description, related foods, and other disease states) provide valuable information for the accurate diagnosis of GERD. Evaluation is often difficult due to the signs and symptoms of GERD which can often be vague and non-specific.

Heartburn is the most common presenting symptom, and other symptoms (e.g., chest pain) may be attributed to other disorders (Table 1). Some atypical GERD symptoms include respiratory problems (e.g., coughing, hoarseness, and wheezing), chest pain, and laryngeal or oropharyngeal symptoms. Dysphagia, weight loss or unexplained anemia may indicate severe disease.

Certain medications and foods can decrease the LES pressure or have a direct irritant effect, thus causing reflux symptom. Tables 2 and 3 list some of the problem foods and medications that can induce reflux symptoms and GERD.

Age is another risk factor for GERD. Infants have decreased gastric emptying and underdeveloped LES tone, thus increasing the risk for reflux. Alternatively, gastric acid secretion decreases with age. However, elderly individuals tend to have decreased salivary production, esophageal peristalsis, and mucosal defense factors (10), but they are still at risk for esophageal irritation and other symptoms of reflux (11). In fact, one study reported heartburn in 14 percent of elderly ambulatory patients and abnormal reflux in 20 percent of this population by ambulatory pH monitoring (12).

Some other risk factors for GERD include cigarette smoking, pregnancy, obesity and scleroderma. Smoking can cause GERD because the nicotine decreases LES pressure. Pregnant women are at increased risk for reflux since circulating progesterone decreases LES pressure and the fetus increases intra-abdominal pressure (12). Also, about 25 percent of pregnant women experience heartburn daily, while 52 percent experience heartburn monthly (1). Obesity can also predispose a person to GERD due to a potential decrease in LES strength and an increase in intra-abdominal pressure.

Diagnostic procedures

Besides reviewing a patient's symptoms, several procedures are available to help diagnose GERD.

Endoscopy and upper GI series are used to image the esophagus and upper GI tract to rule out other diseases (e.g., cancer or peptic ulcer disease) and assess damage to the esophagus. Another procedure, the Bernstein or acid perfusion test, has been widely used since 1958 to determine if atypical symptoms (chest pain or pulmonary symptoms) are caused by GERD. However, due to the occurrence of false-positive results in patients with duodenal ulcers or gastritis, patient subjectivity, and the advent of 24-hour pH monitoring, the use of the Bernstein test is severely limited (13).

In addition, 24-hour ambulatory pH monitoring can detect decreases in intra-esophageal pH which may also correspond to patient symptoms of GERD or reflux, and esophageal manometry may be performed to assess esophageal peristalsis before resorting to surgery (3,4,14).

Table 2. Dietary Factors Which Contribute to GERD (2,4,11,45)

Alcohol
Caffeine
Chocolate
Fatty meals
Orange juice
Peppermint
Tomato juice

Table 3. Medications Which Contribute to GERD (2,4,11,45)

Anticholinergics	Narcotics
Antiparkinson agents	Nicotine
Caffeine	Nitrates
Calcium channel blockers	Phentolamine (Regitine®)
Diazepam (Valium®)	Progesterones
Dopamine (Intropin®)	Prostaglandins E1, E2, A2
Estrogens	Theophylline (various)
Isoproterenol (various)	Tricyclic antidepressants

Management

Therapeutic goals in the management of GERD are designed to relieve patient pain and symptoms, to decrease frequency and duration of reflux, to heal mucosal injury, and to prevent complications and recurrence. Treatment of GERD is usually divided into three phases of therapy.

Phase I therapy usually incorporates lifestyle changes and antacid/alginic acid therapy (9,10,15,16)(Table 4). This therapy helps alleviate symptoms in most patients with very mild GERD, however, neither antacid nor alginic acid therapy promote healing.

If no symptomatic improvement occurs within two to three weeks or if the patient is severely afflicted, Phase II therapy, which consists of pharmacological measures (Table 5), should be initiated. Medications are used for prevention, as well as for treatment of gastric reflux to lower the irritating and erosive factors in the refluxate. Patients with significant GERD should start with both Phase I and II therapies. Phase III therapy is surgery, and it is indicated in about 5 to 10 percent of GERD patients (5,9).

Antacid therapy

Antacids neutralize the gastric acid secreted by the parietal cells in the stomach. By increasing gastric pH, antacids inhibit the proteolytic actions of pepsin. In addition, antacids bind to bile salts (17), and may also exert a cytoprotective effect through increased prostaglandin release, increased mucus production and increased local blood supply (17-20).

There are several types of antacids including sodium bicarbonate, magnesium salts, aluminum salts, and calcium carbonate. Although liquid and chewable tablet formulations are the two most commonly used types,

Table 4: Phase I Therapy for GERD (2,4,16)

Lose weight (if over ideal body weight)
Decrease or avoid certain foods (coffee, citrus, chocolate)
Decrease or stop smoking
Avoid alcohol
Eat smaller meals
Stay upright for 2 hours after meals
Do not eat for 3 hours before sleeping
Elevate head of bed
Avoid tight clothing over abdominal area
Try lozenges to increase saliva production
Antacid/alginic acid therapy

Table 5: Pharmacologic Measures for GERD Treatment (15,27,28)

Generic Name	Brand Name	Initial Daily Dose*	Mechanism of Action#	Cost µø
Antacids	Various	As needed	↓Gastric acidity	7.46/360ml (3.50/360ml)
Alginic acid	Gaviscon	As needed	↑ Esophageal mucosal protection	5.82/360ml (4.73/360ml)
Cimetidine	Tagamet	800 mg	↓Gastric acidity	72.15
Ranitidine	Zantac	300 mg	↓Gastric acidity	82.16
Famotidine	Pepcid	40 mg	↓Gastric acidity	79.80
Nizatidine	Axid	300 mg	↓Gastric acidity	80.56
Omeprazole	Prilosec	20 mg	↓Gastric acidity	106.75
Sucralfate	Carafate	4 gm**	↑Esophageal mucosal protection	78.00
Metoclopramide	Reglan	20 mg	↑LES## pressure, ↑gastric emptying	64.01 (13.20)
Bethanechol	Urecholine	50 mg**	↑ Esophageal clearance ↑ LES pressure	38.70 (2.10)
Cisapride	Propulsid	40 mg	↑LES pressure; ↑peristalsis	72.00

*Higher doses may be warranted if patient fails initial doses

↑ = increase, ↑ = decrease

µ Cost listed is the average wholesale price for a 30-day supply. Costs are taken from the 1993 Redbook(46) using package sizes of 100 for highest strength product, unless otherwise noted.

ø Generic prices, where available, in parenthesis; prices calculated using the average of three products.

**Not FDA approved for GERD

##LES = Lower esophageal sphincter

Table 6: Possible Side Effects of Antacid Therapy (2,16,22,28)

Antacid Salt	Trade Name (Tablets)	Acid Neutralizing Capacity*	Potential Adverse Effects
Sodium Bicarbonate	Various	NAµ	Sodium overload, systemic alkalosis, milk-alkali syndrome
Magnesium	Maalox	21	Diarrhea, hypermagnesemia, magnesium cardiotoxicity
Aluminum	Amphogel#	10	Constipation, systemic aluminum toxicity, hypophosphatemia
Calcium Carbonate	Tums E-X (Extra Strength)	15	Constipation, hypercalcemia, acid rebound

* Acid neutralizing capacity per tablet, capsule or 5 ml of suspension is defined as the mEq of HCl required to keep the antacid suspension at pH = 3.0 for 2 hours.

Liquid dosage formulation

µ Acid neutralizing capacity not available for this formulation

antacids are also available as oral tablets, chewing gum, powder, and lozenges. The various antacid salts, their acid neutralizing capacities and some possible side effects are listed in Table 6.

Sodium bicarbonate is usually not recommended for long-term use because of its high sodium content and its ability to cause systemic alkalosis. Magnesium-aluminum antacid combinations are most commonly used since they minimize or counteract the diarrheal and constipating effects of the magnesium and aluminum salts, respectively.

Several different mechanisms for drug interactions with antacids exist (Table 7). First of all, antacids can bind to other drugs, rendering the bound drug insoluble. Antacids can also change the gastric pH which can alter the rate or extent of absorption, as well as increase urinary pH, which affect the rate of urinary excretion of drugs that are weak acids. To avoid interactions, especially when drugs with narrow therapeutic indexes are prescribed, patients should be instructed to take the medication two hours before the antacid to achieve complete absorption (21).

The cost of antacid therapy depends on the antacid salt, the dosage form and the frequency of administration. Liquid antacids are the most cost efficient formulation due to their higher acid-neutralizing power per unit. However, all antacids must be administered frequently because of their short duration of action (45 to 60 minutes in fasting individuals). This duration increases to approximately two to three hours if the antacid is taken one hour after meals (16).

Antacids can provide symptomatic relief, but have not been shown to promote healing of damaged tissue in GERD patients (20). In addition, third-party insurance programs that cover the cost of prescription drugs, often do not pay for over-the-counter (OTC) drugs such as antacids. Due to these two factors, antacids are best used for symptomatic relief in patients with mild to moderate GERD, as adjuncts to more potent medications.

Alginic acid therapy

Alginic acid, (Gavison®) like antacid therapy, is best used for symptomatic relief. Alginic acid is not an antacid; however, alginic acid preparations usually contain small quantities of antacid to convert alginic acid to sodium alginate, a viscous foam that floats on the surface of the gastric contents. If reflux occurs, the sodium alginate provides a barrier preventing acid exposure to esophageal mucosa. Thus, the amount of antacid in alginic acid preparations is not sufficient to alter gastric pH (16).

Alginic acid preparations are considered to be at least as effective as antacids for relieving symptoms, however, like antacids, alginic acid preparations do not promote healing in GERD patients (16,22).

Histamine-2-Receptor Antagonists (H2RAs)

Cimetidine (Tagamet®), ranitidine (Zantac®), famotidine (Pepcid®), and nizatidine (Axid®) are the four H2RAs currently available in the United States. H2 receptor antagonists inhibit binding of histamine to H2 receptors in the parietal cells of the stomach, resulting in decreased gastric acid secretion.

Bioavailability ranges from 30 percent with cimetidine to 75 to 100 percent with nizatidine (23). For all four agents, serum protein binding is relatively low; e.g., 15% to 20% for cimetidine, ranitidine, and famotidine, and up to 35% for nizatidine. Their elimination half-lives can range from 1 to 4 hours (23). Advanced age and liver impairment lower cimetidine clearance, but appear to have little effect on the other H2RAs. Since all four drugs are renally excreted, dosage reductions are recommended in patients with renal impairment.

Overall, the H2RAs cause few serious adverse effects. The most common adverse effects, though, are diarrhea, headache, drowsiness, fatigue, muscle pain and constipation, all of which are reported in less than 3 percent of patients (27).

Due to its structure, cimetidine has a greater ability to cross the blood brain barrier which may increase the likelihood of CNS-related effects, especially in elderly patients. Although cimetidine and ranitidine can increase serum prolactin levels which may result in breast swelling and galactorrhea in females and gynecomastia in males, famotidine and nizatidine do not. Impotence has been implicated with cimetidine therapy; but this condition usually reverses within one month after switching to ranitidine (23). Cimetidine has also caused loss of libido. Finally, while elevations in serum levels of the aminotransferase enzymes are usually reversible, hepatitis has rarely occurred (23,24).

The H2RAs can increase gastric pH, thus decreasing the absorption of drugs dependent upon an acidic environment, e.g., ketoconazole (Table 7). Other drug interactions with the H2RAs are due to their inhibition of cytochrome P-450 enzymes which are involved in the hepatic metabolism of some drugs. While cimetidine is the most potent inhibitor of cytochrome P-450, ranitidine binds five to 10 times less, and famotidine and nizatidine do not bind significantly (23). Through competition, H2RAs may also inhibit renal tubular secretion of certain drugs.

Dosing of the H2RAs for GERD depends upon the individual and the severity of the disease. Generally, clinicians initiate GERD therapy with standard duodenal ulcer treatment doses, but in most cases, much higher doses of H2RAs are required to treat and manage GERD symptoms. Studies show that H2RA therapy relieves reflux symptoms in about 75% of patients; however, healing may be inadequate using standard doses since only about 33% of patients are healed (4).

For example, patients given ranitidine 150 mg twice a day for erosive or ulcerative esophagitis showed healing rates after four and eight weeks of 31% and 50%, respectively (25). Healing was defined as macroscopically complete epithelialization of all erosive or ulcerative lesions of the esophagus. Comparing nizatidine 300 mg twice a day, 300 mg at bedtime, and placebo showed six-week healing rates of 40%, 30%, and 26 %, respectively (23).

Since approximately 50 percent of GERD patients fail H2RA therapy, even at twice the standard dose for duodenal ulcer (16), many studies have evaluated high dose or high frequency H2RA therapy. In one study comparing ranitidine 300 mg four times a day with ranitidine 150 mg

Table 7: Selected Clinically Significant Drug Interactions of GERD medications (16,21,23,26,28)

GERD Medication	Object Drug	Proposed Mechanism*
Antacids	fluoroquinolones tetracycline isoniazid iron preparations	decreased bioavailability of object drug through binding
H-2-receptor antagonists	itraconazole ketoconazole enoxacin	decreased bioavailability of object drug due to increased pH of stomach
	warfarin phenytoin theophylline	possible increase of object drug concentrations due to hepatic metabolism
	procainamide triamterene	increased concentrations of object drugs through inhibition of renal tubule secretion
Omeprazole	diazepam phenytoin warfarin	increased concentrations and decreased clearance of object drugs due to inhibition of P-450 enzyme system
	ketoconazole itraconazole iron preparations	decreased absorption of object drugs due to increased pH
Sucralfate	digoxin warfarin phenytoin theophylline	possible decreased concentration of object drug due to chelation/binding
	aluminum-containing antacids	possible increased aluminum serum levels
Bethanechol	cholinergic drugs	additive effects
	quinidine procainamide	decreased effects of bethanechol
	ganglionic blocking agents	decreased blood pressure
Metoclopramide	anticholinergic drugs opiates	decreased metoclopramide effects due to decreased GI motility
	antihypertensives alcohol CNS depressants	increased CNS depression
	digoxin cimetidine	decreased absorption of object drugs due to increased GI motility
Cisapride	Anticoagulants	possible increased coagulation times, adjust dose accordingly

* Abbreviations: GERD = gastroesophageal reflux disease; GI = gastrointestinal; CNS = central nervous system

twice a day, complete healing of esophageal ulcers or erosions occurred in 63% and 75% of the "high-dose" patients after four and eight weeks, while 29% and 54% of the "standard-dose" patients were healed (15,23). In addition, some patients have required up to 3,600 mg of ranitidine per day to promote healing (26).

While H2RAs are generally considered to be safe and well tolerated, studies to determine their safety at high doses have not been done, therefore, the lowest effective dose should always be used. In addition to higher doses, H2RA therapy for GERD needs to be given at least twice a day or more. Split-dose therapy will inhibit both daytime and nocturnal acid secretion which will relieve symptoms, promote healing, and improve overall outcome for the patient (27). Unlike patients with duodenal or gastric ulcers, GERD patients frequently require prolonged, treatment doses of H2RA therapy (2).

Omeprazole

Omeprazole (Prilosec®) is a substituted benzimidazole that suppresses gastric acid secretion by irreversibly and non-competitively inhibiting the acid proton pump of the parietal cell. Acid suppression is profound and a single dose will suppress acid by more than 90% for 24 hours (15). Maximal antisecretory activity and plasma levels occur about two hours after an oral dose.

Omeprazole has a high first-pass-effect; bioavailability is only about 30%-40% of an oral dose and protein binding is high, about 95 percent (28). Almost 80 percent of the drug is eliminated renally as six metabolites which have little or no antisecretory activity. The other 20 percent of the drug is excreted through the biliary system. Although the elimination half-life is about two to three hours (29), the antisecretory action of omeprazole can last up to 72 hours due to prolonged proton pump binding (28). Dosage adjustments are not necessary in patients with renal impairment, and omeprazole has no effect on renal tubular handling of acid or on renal electrolyte excretion (29). Although dosage adjustment is unnecessary in patients with hepatic impairment, liver disease increases omeprazole's bioavailability and decreases its clearance; nevertheless, these patients should be monitored for adverse effects.

One issue concerning widespread use of omeprazole is its long-term safety profile. In two-year studies in rats, a dose-related increase in gastric carcinoid tumors was seen, however, data from patients with Zolinger-Ellison Syndrome (ZES) who received omeprazole for up to 4 years, revealed no detectable carcinoid tumors (30,31).

Omeprazole has few adverse effects, but its most frequent complaint is headache, which occurs in approximately 7% of patients. Diarrhea, abdominal pain, nausea, upper respiratory infection, vomiting, dizziness, and rash have also been reported, but in less than 4% of patients (28).

Since Omeprazole inhibits the isoenzyme IIc of the P-450 enzyme system, it has the potential to interact with other drugs metabolized by this route (Table 7). In addition, a catatonic reaction was reported in a patient receiving disulfiram (Antabuse®) and omeprazole (29). The clinical significance of these interactions has not been determined, but close monitoring is recommended. In addition, omeprazole increases gastric pH so serum concentrations of drugs that require an acidic environment for absorption can be decreased (28,29).

Currently, the FDA has approved omeprazole for severe erosive esophagitis and for poorly responsive symptomatic GERD, including patients demonstrating an inadequate response to H2RA therapy. Studies comparing omeprazole once daily with H2RAs or placebo have been favorable. In a study of 230 patients with reflux esophagitis, 74% of the patients on omeprazole 20 mg/day and 75% of patients on 40 mg/day were healed after eight weeks, compared to 14% of patients receiving placebo (32). Meta-analysis of trials comparing omeprazole (20 or 40 mg/day) with ranitidine (300 mg/day) showed a significantly better healing rate for patients on omeprazole after four and eight weeks (32).

Omeprazole has been shown to be effective in patients with resistant esophagitis despite H2RA therapy. Ninety-eight patients with persistant esophagitis after three months or more of ranitidine or cimetidine therapy were randomized to either omeprazole 40 mg/day or ranitidine 300 mg twice a day. After 12 weeks, 90% (46 of 51 patients) receiving omeprazole were healed compared to 47% (22 of 47 patients) on ranitidine ($p < 0.001$) (33).

Bardhan and colleagues (34) studied 45 patients with refractory esophagitis despite at least three months of either cimetidine 3.2 gm/day or ranitidine 900 mg/day. These patients were subsequently treated in an open trial with omeprazole 40 mg/day for up to eight weeks. After four and eight weeks, healing occurred in 73% and 91% of patients, respectively (32).

Dosing and length of therapy of omeprazole are somewhat controversial. Currently, only 20 mg/day is FDA-approved for GERD, however, higher doses have been used in refractory patients (35). The manufacturer recommends that an initial dose of omeprazole 20 mg/day be used for at least four weeks before considering increasing the dose to 40 mg/day (27). Length of treatment is usually four to eight weeks, with an additional four weeks if healing has not occurred. Maintenance therapy with omeprazole is effective, but remains a concern due to the appearance of gastric carcinoid tumors in rats given high doses over long periods of time.

Since it is acid labile, omeprazole is composed of enteric-coated granules. The capsules should not be crushed or mixed with food or enteral feedings (27), however, omeprazole granules have been mixed with acidic fruit juices for patients who cannot swallow capsules or require administration via a naso-gastric tube (16).

Due to its once daily dosing, efficacy, and cost, omeprazole may soon be considered as first line Phase II therapy for GERD. A decision analysis was performed to assess clinical and economic effects of three treatments; i.e., Phase I therapy alone or in combination with either omeprazole (20 mg/day) or ranitidine (150 mg bid) therapy. Although the omeprazole therapy was the most expensive, it reduced GERD symptoms and overall payments by the third-party payor for treatment of complications and surgery (36). Comparing cost-effectiveness of omeprazole (40 mg/day) and ranitidine (300-600 mg/day) therapy, omeprazole produced higher healing rates as well as faster healing rates. In addition, omeprazole-treated patients used less antacids; projected endoscopy use decreased because clinicians had more confidence in omeprazole's healing ability, so the authors concluded that omeprazole was more cost-effective than ranitidine (16).

Sucralfate

Although sucralfate is used clinically to treat GERD in some settings, this agent is not FDA approved for GERD treatment. Sucralfate is a sulfated disaccharide complex with aluminum hydroxide that adheres to damaged mucosal tissue to create a barrier to the irritant effects of acid, pepsin, and other components of gastric contents. It does not alter pH of the gastric contents or affect gastric acid secretion (27).

Since there is virtually no absorption of sucralfate, adverse systemic effects are uncommon. Sucralfate is well-tolerated, with constipation being the most commonly reported adverse effect. However, the aluminum in sucralfate may be absorbed which can be a potential problem in renally impaired patients (37). Additionally, chronic ingestion can result in increased aluminum serum concentrations; hypophosphatemia can occur secondary to sucralfate binding of dietary phosphate (2).

Sucralfate tablets can be swallowed or dissolved in water to make a suspension, and a suspension formulation is now being manufactured. Drug interactions with sucralfate usually result from chelation by the aluminum portion of the molecule (Table 7). Drug-drug interactions may be avoided by administering medications at least two hours before sucralfate administration (16).

Results of studies on sucralfate's efficacy in GERD have been inconsistent. In a study of 18 patients with esophagitis who received sucralfate 1 gm four times daily, 94% showed improvement after 12 weeks (2). However, a multicenter, randomized, double-blind, placebo-controlled trial was unable to demonstrate significant differences between sucralfate suspension (1 gm after meals and 2 gm at bedtime) or liquid placebo treatment (38).

Although anecdotal reports suggest that sucralfate is effective in some patients, especially those with mild esophagitis, further studies are necessary to confirm its efficacy.

Prokinetic agents

Drugs that increase transit time of material throughout the gastrointestinal tract are called prokinetic agents. Currently, the three prokinetic agents available in the United States are bethanechol (Urecholine®), a cholinergic agonist; metoclopramide (Reglan®), a dopamine-receptor antagonist; and cisapride (Propulsid®), a serotonin-4 (5-HT4) agonist. Erythromycins also increase gastric motility, but are not currently being used for GERD treatment (39).

Bethanechol increases LES pressure, amplitude of gastrointestinal contractions, and esophageal clearance, but it has no effect on gastric emptying or coordination of gastrointestinal contractions. For this reason, bethanechol is sometimes not considered a true prokinetic agent (4,39). In addition, bethanechol can increase gastric acid secretion which could negatively affect a GERD patient (5,39,40).

Bethanechol is poorly absorbed, taking up to 90 minutes before its full gastrointestinal effects are seen (16). In addition, patients do not tolerate bethanechol well. Adverse effects are related to its cholinergic actions and include abdominal pain and cramps, diarrhea, urinary frequency, blurred vision, sneezing, sweating, salivation, and increased blood pressure (15,16,40). Bethanechol is relatively contraindicated in patients with asthma, chronic obstructive pulmonary disease, and peptic ulcer disease (2).

Metoclopramide increases LES pressure and gastric emptying. Although data are conflicting, metoclopramide may also increase esophageal peristalsis and clearance (2). Absorption is rapid and virtually complete; however, it may take up to 60 minutes for the GI effects to occur (16). The elimination half-life of metoclopramide is 2.5 to 5 hours and it is excreted in the urine (39).

As with bethanechol, metoclopramide produces a number of adverse effects. Drowsiness, jitteriness, tremors, nightmares, anxiety, and depression can occur. Neurologic and dystonic reactions also have been reported (4,16). Because metoclopramide can alter GI transit time, absorption of other drugs may be affected (Table 7). Use of medications that decrease GI motility can hinder metoclopramide's effect. In addition, use with some antihypertensives and other medications that depress the CNS may lead to enhanced CNS depression.

Cisapride, a newer oral prokinetic agent, appears to have a more favorable side effect profile than metoclopramide. Its mechanism of action is enhancement of release of acetylcholine at the myenteric plexus. In vitro, it acts as a serotonin-4 (5HT) receptor agonist; this agonist action may result in cisapride's ability to increase GI motility.

Cisapride is rapidly absorbed after oral administration and peak plasma concentrations are reached in 1 to 1½ hours. It is approximately 35%-40% bioavailable, and about 98% bound to plasma proteins. The recommended dose of this medication is 10 mg four times daily (28). In two placebo controlled studies, 10 and 20 mg four times daily showed beneficial effects on nighttime regurgitation, however, in another placebo controlled study, these effects were not seen (41).

The advantage of cisapride appears to be its better safety profile; the most commonly reported side effects were dizziness, vomiting, pharyngitis, chest pain, back pain, depression, dehydration and myalgia (all reported to be greater than 1%) (28).

Study results with the currently available prokinetic agents for GERD treatment have been conflicting. However, because of their poor tolerability, these agents are not commonly used alone, and are primarily reserved for adjunctive therapy with H2RAs (4).

Maintenance therapy

Once healing or symptomatic relief has been achieved in GERD patients, maintenance therapy frequently is necessary. In patients with healed esophagitis, as many as 80%-90% experience relapse after six months (33,42). Due to their established safety profile during long-term therapy, the H2RAs are most commonly used as maintenance therapy in GERD patients (4). However, typical maintenance doses for duodenal ulcers (e.g., ranitidine 150 mg once daily) often lead to relapse in many patients.

In a randomized, double-blind trial of 61 patients with healed esophagitis, relapse rates of 42%-36% occurred after six months of ranitidine 150 mg at bedtime and placebo, respectively (43). In a 12-month comparative trial, no significant differences in relapse rates were seen in patients treated with either placebo, cimetidine 300 mg twice daily, or cimetidine 400 mg at bedtime (2,22). To prevent recurrence, it appears that gastric acid suppression must occur throughout the day and night. Small studies have shown that H2RA therapy at standard peptic ulcer disease doses may prevent relapse (22).

Omeprazole has also been studied for possible maintenance therapy. In a study of 73 patients with healed

esophagitis, 19 percent (14 of 73 patients) experienced an endoscopically-determined relapse after six months of omeprazole 20 mg once daily. Of these 14 patients, 12 healed after increasing the dose to 40 mg. once daily; the remaining two patients healed after increasing the omeprazole dose to 60 mg daily (43). In a comparison of omeprazole (20 mg daily) with ranitidine (150 mg twice daily), 25 percent of the omeprazole-treated patients relapsed after one year while more than 80 percent of the ranitidine-treated patients suffered relapses (2).

Although omeprazole appears to be effective in preventing recurrences, concerns exist regarding omeprazole's long-term safety. Currently, peptic ulcer disease treatment doses (divided into multiple daily doses) of H2RA therapy is the recommended therapy for GERD prophylaxis (4,22,44). Omeprazole should be reserved for patients who fail H2 receptor antagonist maintenance therapy. No studies have yet determined the most appropriate length of time a patient should remain on maintenance therapy.

Conclusions

Proper identification of both the classical and atypical presentations of GERD need to be made to avoid potential complications of untreated disease such as hemorrhage, obstruction, aspiration or malnutrition. In mild cases, GERD can be treated with antacid or alginic acid therapy, as well as non-pharmacological measures; with more severe disease, H2RAs or omeprazole are recommended. These drugs have proven efficacy in suppressing gastric acid secretion and in promoting healing of damaged tissue in GERD patients.

The H2RAs need to be given at least twice daily and, if necessary, in high doses (e.g., ranitidine 600 to 900 mg daily) for at least eight weeks. Omeprazole treatment should be initiated at 20 mg daily for four to eight weeks, although higher doses may be necessary (e.g., 40 to 60 mg daily). If healing has not occurred after an eight-week trial, omeprazole can be continued for another four weeks. Maintenance therapy is often necessary for GERD patients even after healing has occurred; H2RAs in split doses or omeprazole once daily can be used to prevent disease recurrence.

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All persons designated as authors should qualify for authorship. Each author should have participated sufficiently in the work to take public responsibility for the concept.

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Tables (tabular listings) and figures (photos, drawings and charts) should be numbered, and the point of reference in the text indicated in parentheses, i.e. (Table 1), (Figure 10). Photos must be unmounted glossy prints in a 5 in. x 7 in. format or smaller. Black and white photos are preferred. Cost of printing photos in excess of four will be billed to the author. Each photo should have a label pasted on its back indicating its number, the author's name and an indication of its "top." Do not write on the back of photos, scratch or mar them with paper clips, or mount them on cardboard. Drawings and charts should be done in solid black on pure white.

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Exercise Induced Anaphylaxis: One more cause for syncope

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Abstract

Syncope is a very common problem. Young people who exercise regularly are considered to be in "good health," so when they complain of passing out during exercise, it must be treated as a serious condition. Exercise Induced Anaphylaxis (EIA) is a well known cause for syncope in sports medicine and allergy literature. A patient's history is critical in making this diagnosis. With the current exercise boom, internists and family practitioners need to be even more aware of EIA when patients complain of syncope with physical activity.

Case report

A 26-year-old attorney was brought to the Emergency Room at CAMC, General Division, in stable condition after "almost passing out" following a vigorous game of basketball. He had not experienced any chest pain or palpitations during the game, however, a physician friend who was playing with him noted that his pulse was in the upper 90's and regular, but that his blood pressure was not palpable. His BP became normal after 2,000 cc. of Ringer's Lactate solution.

On examination, he had urticarial lesions on his trunk which responded to intramuscular diphenhydramine. He was kept on telemetry overnight and no arrhythmia was noted. He told the physicians he had experienced syncope three months previously after a game of basketball and near syncope two times in 1989, once while playing baseball and once while jogging. He also reported that he had noticed pruritic hives appearing on his body recently, as well as in 1989 when he experienced the two episodes of near syncope.

Family history revealed that his father had many allergies. Physical examination and routine tests were within normal limits. He underwent a stress echocardiogram and a tilt table test which were both within normal limits. A diagnosis of EIA was strongly considered at this time, and an allergist who examined the patient later agreed the history was strongly suggestive of EIA.

This patient decided to continue to exercise. He jogs in the morning now and always carries an Epipen. He takes hydroxyzine in the evening.

Discussion

EIA was first described in 1979 as three separate entities (1). One form is Cholinergic Urticaria (CU), in which patients develop small papular eruptions associated with each bout of exercise. These eruptions can be precipitated by heat, as when taking a warm shower. Wheezing may also occur. This does not progress to anaphylaxis.

Individuals with the second type or classic EIA develop large urticarial lesions. This does not happen each time the patient exercises, but whenever it does occur, it is always associated with exercise. Symptoms of pruritus, urticaria and flushing can progress to angioedema or vascular collapse. They can also have profuse sweating, colic, respiratory symptoms and a headache. This cannot be precipitated by passive warming. It is difficult to make a diagnosis of both CU and classic EIA under controlled conditions. Both can cause an increase in serum histamine levels. A third kind of EIA is a variant type in which the individual has skin lesions similar to CU but can progress to anaphylaxis.

Two-thirds of the patients with EIA have a family history of atopy (2). Females are more frequently affected, especially during their menstruation. The mean age of onset is around 25 years, but varies from age 4 through 80 (1).

Jogging is the most frequently mentioned activity associated with EIA, though any vigorous physical activity can cause this condition. Usually symptoms develop when the patients are approximately five minutes into the exercise. Patients can very often predict when an attack is going to occur, and 54% of patients with classic EIA report eating celery, shellfish or wheat 20 minutes to one hour before an episode occurs (1). Drugs like aspirin or NSAIDS can also precipitate an episode.

Treatment for an acute attack involves mainly the same regiment as any anaphylactic reaction, i.e. epinephrine, fluids and maintenance of the airway. Prevention is more important. Patients should be well educated about their condition and be told that avoiding exercise is the safest alternative (even though this is not acceptable to many patients), and how to use an anaphylaxis kit (Epipen). The Epipen kit should be carried whenever they exercise, and they should exercise with a person who knows how to administer the medications contained in the kit. In addition, patients should be instructed not to exercise after ingestion of food, aspirin or NSAIDS, and females should not exercise during menstruation.

Antihistamines like diphenhydramine and hydroxyzine are somewhat effective in the prevention of EIA, but the side effects are not acceptable to many patients. Newer antihistamines have been tried with varying success, and cromolyn sodium (Intal) does help in some patients (3).

Individuals with EIA may also benefit from regular exercise since they may induce tolerance to exercise, manifested by reduced peak histamine levels and EIA symptoms (1). Recently, a mention of the association of H. pylori infection and EIA was made by Dr. Steven Kagen at the Annual Meeting of the American Academy of Allergy and Immunology.

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Protecting our children

By this time, I hope that you are already aware that my health project for the WVSMA Alliance this year is *"Combating the Negative Effects of the Media on Children and Youth."* It is frightening how pervasive the negative effects of media have become in our society over the last 20-30 years, and WE MUST PUT A STOP TO IT in order to save today's children from a further deterioration of life as we've known it!

Perhaps you aren't aware of the extent of this problem. If you are not, I urge you to read the fall issue of the AMA Alliance's magazine *FACETS*, cover to cover. At this time though, I would like to discuss another problem which had arisen as a result of the "information age" - - the exposure of children to pornography through " on-line computer services!"

If you have children or grandchildren, or children you care about who are using online computer services, you need to be aware of what they may be accessing. Even though computers are educational tools that our children should have access to, the computer networks are becoming saturated with pornography and "your" kids may be signing on!

The August issue of *Woman's Day* magazine had an article entitled *"Password-Porn"* that I'd like to highlight for you. This article stated that computer-saavy children are being exposed to many things which parents literally can't conceive of - - from grabbing erotic photos off of phone lines to engaging in "cybersex" (having sexually explicit conversations with other users).

The technology behind this new menace is NETWORKING, the process of connecting computers to one another through the telephone lines. Networking is the system that forms the backbone of the "information superhighway," an incredible advancement for society, yet a dangerous one because it allows your children to invite the entire world into your home through your personal computer! The vast information superhighway is a very scary place because there is absolutely NO regulation or control over it, and most parents have no idea what's out there or how easy programs can be accessed.

On the uncensored global computer network known as Internet, users are swapping X-rated photos, trading sexually explicit stories, and joining discussion groups on topics ranging from how to steal credit-card numbers to bestiality and incest. It is shocking that 150,000 accounts are now in schools, and that number is expected to grow to 1.5 million within three years!

There is no way to totally block access to these types of programs because there is no centralized management of Internet resources. In addition, there is literally no one to complain to about Internet because it is barely organized at all; it's merely an interconnection of computer networks around the world, with no central authority!

Some examples of other problems created by "on-line" services:

— In the "anarchy files" on Internet and other electronic sources, children can easily find instructions on how to build pipe bombs or cause other kinds of mayhem.

— Computers are increasingly being used by child molesters to find and meet their young victims;

— Children often innocently wander into inappropriate areas while on-line because they are misled by innocuous sounding names. One example was an 8-year-old girl who was discovered in an electronic discussion group called "*TV Chat.*" This girl thought the group was going to be talking about TV, but it was really discussing transvestites!

The first and most important rule of computer safety is: Don't ever allow your child to give out personal information on-line! Computer communication is anonymous; you never really know to whom you are talking, consequently, your children should be taught never to give their real names, addresses or phone numbers to anyone they meet on-line.

Also, be careful to keep close tabs on your children's on-line activity. Parents who vigorously monitor their children's TV watching and would never dream of leaving a 7-year-old alone at a shopping mall, might not think twice about letting that same child go on-line alone for hours at a time. If your child is tying into any bulletin boards with your computer, you should supervise what he or she is doing, whether they are 7 or 17 years old.

SO, WHO'S PROTECTING OUR CHILDREN?

The future of today's children is in our hands! It is up to us as parents and leaders in our communities to help protect our children from the many negative influences surrounding them.

Sue Bryant
WVSMA Alliance President

Battle of the Bulge: A remembrance

Editor's Note: Dr. Glover is a professor of obstetrics and gynecology at the Robert C. Byrd Health Sciences Center of West Virginia University. He served in the Korean War and has been a military historian ever since his days in the service.

At 0530 on Saturday, December 16, 1944, the U.S. VIII Corps front in the Ardennes - - a sector that had been inactive for several months - - suddenly became engulfed in a massive artillery barrage. Within hours, 25 German infantry and Panzer divisions overwhelmed the American defenders on an 85-mile front (1). Hitler's last great counteroffensive of World War II had begun.

A drive from the German border through the Ardennes to Antwerp (a distance of 100 air miles) would trap the British and Canadians as well as the U.S. First and Ninth Armies, fully half of the Allied forces on the Continent. If successful, such an offensive could lead to a second Dunkirk. Optimistically, Hitler believed he could then make peace on terms acceptable to the Third Reich (2).

The VIII Corps sector was being used by the First U.S. Army to rest battle-worn divisions and to introduce green ones to combat. Two of the corps' three divisions had recently been relieved from combat after sustaining heavy casualties (3). A third, the 106th Infantry Division, had embarked from the U.S. on the 20th of October and arrived on line just six days before the attack (4).

The Germans attacked with three armies and had a numerical advantage of 250,000 to 83,000 men, as well as numerical superiority in artillery and armor (5). They achieved complete surprise. In short order, one American division was destroyed, two others were crippled, and an armored combat command was eliminated. Thousands of American soldiers were killed, wounded, or captured. Nevertheless, the timetable for the attack almost at once fell behind schedule, largely due to the tenacity of individual American units (6,7).

Bastogne was the key to the entire road net on the southern flank of the German advance. Continued occupation, therefore, was essential for the Allies to mount a counter attack. General Eisenhower's strategic reserve consisted solely of the 82nd and the 101st Airborne Infantry Divisions, so on December 19 he ordered both divisions into action and moved the 101st Airborne to Bastogne to set up defensive positions (8).

Medical support for the division was provided by the 326th Airborne Medical Company, which was organized and equipped for self-sufficient operations out of contact with the normal ground chain of evacuation. Both collecting and clearing elements were included in its structure, and an auxillary surgical team was attached so the unit could function as a field hospital.

Anticipating that the German attack would come from the east, the medical company commander set up the clearing and surgical station eight miles to the west of Bastogne, well to the rear of the anticipated action (9).

On that evening of December 19, a German armored reconnaissance force that had bypassed Bastogne caught the medical company by surprise and, after a brief fire fight, accepted their surrender. The commanding officer and his staff, the entire auxillary surgical team, and 130 officers and men from the unit were taken prisoner (10). Adversity eliminated the principal medical support of the 101st Airborne Division before it could become fully operational. Two days later the Germans closed the ring. Bastogne was completely surrounded.

The situation was deplorable. The weather was bitterly cold and everything was in short supply. Those still fit to fight relinquished blankets to protect their wounded comrades from exposure. Artillery ammunition was nearly expended. Yet, despite concentric attacks by three German divisions, the *"Battered Bastards of Bastogne"* held on (11).

To commemorate the 50th anniversary of the Ardennes counteroffensive, a feature article appears on page 506 in this issue of the *West Virginia Medical Journal* focusing on the achievements in that battle of Dr. Henry M. Hills Jr., a well-known Charleston orthopedic surgeon. This is indeed appropriate, because the outcome of the Battle of the Bulge (which actually hastened the German defeat) was as much a result of small unit actions and the dogged determination of the individual American soldier as it was of command decisions.

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In My Opinion

Managed care = veterinary care

West Virginia is becoming more and more affected by the managed care mania which is sweeping the country. Doctors are scrambling to understand and adjust to the new environment. Implicit in the development is the notion that health care costs will be lowered, but there is a paucity of data that this is so. Nationwide at least 25% of the insured population are in HMOs and many more are in managed care plans -- with no discernable savings to date.

The Congressional Budget Office has concluded that there is no evidence that managed care saves money. A study of Medicare recipients in HMOs concluded that it costs the government 6% more than in private, fee-for-service plans, despite the fact that the payment to the HMOs was pegged at 95% of average Medicare disbursements. The explanation is that the HMOs enrolled the Medicare recipients who are 65-70 years of age and still working, and not the 85-year-old nursing home residents.

Even though the Clinton administration has boosted managed care by utilizing 500 "experts" who were all in managed care to help plan the president's proposal for health care reform, the real push comes not from the politicians, not from the patients, certainly not from the doctors and other providers, but solely from the insurance companies. Managed care does not lower the cost of care, however, it does lower the percentage going to the provider and increases the cost of administration, already the biggest in the world and a major cause of the present problem.

Understanding managed care is not difficult if you understand the concepts of veterinary medicine. In veterinary medicine, it matters not what the patient wants -- it only matters what the owner wants. So, it is in managed care -- the insurance companies talk and act as if they **own** the patients and behave accordingly.

In veterinary medicine, the size of the herd is critical. The man with 100 head of cattle gets more consideration than the little girl with her kitten. In managed care, they talk of "covered lives;" the more employees you have in your company, the bigger the discount your company will receive from standard prices.

Veterinary care is also a great equalizer. Even if you just won the Kentucky Derby, if you break your leg you will be shot. The parallels are that end-of-life decisions are now more likely to be dictated by the managed care plan and the CEO of the company will, presumably, be treated the same as the janitorial staff.

In veterinary care, the same medicines used in human medicine are far cheaper. This is particularly true of farm animals raised for food as opposed to pets because there are definite fiscal constraints on medical care. This same principle applies with managed care, where the cheapest therapy is the preferred choice.

In human medicine, the detailed history is 85% of the diagnostic armamentarium. In veterinary medicine if there is no history, the history and the treatment recommendations are given by the owner. Objective criteria are more important. Managed care, too, tends to discount the individual history. Cases must be pigeonholed into CPT or ICD-9 categories and dealt with accordingly.

Managed care will destroy the physician-patient relationship. In veterinary care, there is only a superficial relationship between the veterinarian and the animal. The major relationship is with the owner -- the payor for care.

To be fair, there are differences. Veterinary care tends to be cash and carry with a minimum of paperwork and insurance forms. Managed care is a thicket of regulations, paperwork, rules, penalties, traps, evasion and obfuscation.

What is the solution? Over the last two to three decades, medicine and all social institutions have gradually become larger and larger entities. The ability of a solo practitioner to modify the terms of a managed care contract to which he/she objects is nearly zero. Doctors must organize and band together either loosely or formally to negotiate as a group. Furthermore, we must educate our patients -- they have more clout than we have with their employers, and therefore, their insurance programs. Finally, we must push the concept of medical savings accounts as a viable alternative. The politicians say it is politically unattainable and unworkable, however, it is working for the employees of the Golden Rule Insurance Company, for the citizens of Jersey City, N.J., and in the state of Idaho.

Managed care is social engineering that makes George Orwell, the author of *1984,* look like a British optimist. Managed care is an oxymoron: the people doing the managing are opposing those who do the caring. **We must remember, we are physicians, not veterinarians.** Whether we succeed or not, we must preserve the traditions of medicine that have endured for centuries and made doctors the most eminent champions of humankind.

Wallace D. Johnson, M.D.
Beckley

Mark Your Calendars!!
Please Attend

The 1995 WVSMA Legislative Briefing & Reception

at the Charleston Marriott
Wednesday, February 8

Briefing - 5 - 6:30 p.m.
Reception - 6:30 - 8 p.m.

Please R.S.V.P. by February 3
925-0342

At Mid-Winter

Session on controversies to discuss coronary artery disease, mammography

This year's Second Scientific Session, "*Controversies in Medicine*," at the WVSMA/WVACP's 1995 Mid-Winter Seminars and Scientific Conferences will be devoted to the pros and cons of "*Screening Mammography*" and the medical vs. surgical treatment of "*Coronary Artery Disease*." This session will take place on Saturday, January 21 at 9 a.m. at the Radisson Hotel in Huntington.

The pros of screening mammography will be addressed by **Judy Schreiman, M.D.**, a professor and vice chair of the Department of Radiology at the WVU School of Medicine in Morgantown; and the cons on this subject will be presented by **Daniel S. Foster, M.D.,** a clinical professor in the Department of Surgery at the WVU School of Medicine, Charleston Division. Discussing the medical treatment of coronary artery disease will be **Robert C. Touchon, M.D.**, a professor of medicine and physiology at Marshall University, and **Ronald C. Hill, M.D.**, an associate professor of surgery at the WVU School of Medicine in Morgantown, will lecture on the surgical treatment of this disease.

Information about these speakers begins below. A registration form for the conference appears on page 527, and more details about the meeting can be obtained by phoning Nancie Divvens at (304) 925-0342.

Foster

Touchon

Hill

Session presenters highlighted

Dr. Schreiman is a native of California, who received a nursing degree from San Jose State University in 1972. After nursing school, she earned her A.S. and P.A. certification from Foothill College/Stanford University Medical Center and then enrolled in Michigan State University, where she obtained a B.S. degree in psychology in 1976 and her medical degree in 1980.

Following medical school, Dr. Schreiman did a four-year residency in diagnostic radiology at the Mayo Clinic and became an instructor in the Department of Radiology at the University of Minnesota. In 1985, she was promoted to assistant professor at the University of Minnesota, but she left the next year to accept the posts of assistant professor and director of the residency program in the Department of Radiology at Creighton University in Omaha, Neb.

In 1989, Dr. Schreiman was named vice chair of the Department of Radiology at Creighton, and she was elevated to associate professor. She was on the faculty at Creighton until 1992, when she relocated to West Virginia to become professor and vice chair of the Department of Radiology at the WVU School of Medicine. In addition to this role, Dr. Schreiman is also section chief of mammography at WVU and medical director of the Betty Puskar Breast Care Center.

A diplomat of the American Board of Radiology, Dr. Schreiman is a member of many professional radiological organizations and is currently the investigator or principal investigator for four grant projects involving breast cancer education and research.

Dr. Foster was born in Oak Ridge, Tenn. He received a B.A. degree from Harvard University in 1970 and his medical degee in 1974 from the Stanford University School of Medicine.

After completing his internship at Charity Hospital of Louisiana at New Orleans and a residency in surgery at Tulane University, Dr. Foster went into private practice for general and vascular surgery in Charleston. Since he opened his practice in 1979, he has also been on the faculty of the WVU School of Medicine as a clinical professor in the Department of Surgery.

A fellow of the Southeastern Surgical Congress and the American College of Surgeons, Dr. Foster is also a member of several other medical organizations including the Alton Ochsner Surgical Society, the West Virginia Gastrointestinal Society, and the Tulane Surgical Society. He is also chairman of the WVSMA's Mid-Winter Clinical Conference Committee and is a member of the WVSMA's Committee on Medical Education.

Dr. Touchon earned his medical degree from Saint Louis University in St. Louis in 1965. He did residencies in internal medicine at Santa Barbara General/Cottage Hospitals in Santa Barbara and at the University of Pennsylvania

After his residencies, Dr. Touchon was a fellow in clinical cardiology from 1968-69 at Saint Vincent Hospital at the University of Southern California. He then completed a fellowship in cardiology research at the University of California at Los Angeles.

In 1970, Dr. Touchon joined the U.S. Air Force and served for two years as a medical corp flight surgeon, as well as the director of the catherization lab and chief of the cardiopulmonary research

function at Brooks Air Force Base in Texas. During this time, he also taught physiology and medicine at the University of Texas Medical School in San Antonio.

Following his military service, Dr. Touchon returned to California to accept a position as medical director of the Cardiac Diagnostic Institute in Fullerton. In 1974, he was named director of cardiac rehabilitation at the institute, and in addition became director of coronary care at Anaheim Memorial Hospital in Anaheim. From 1975-77, Dr. Touchon held a variety of management roles at the two facilities and was a clinical instructor of medicine at the University of California at Irvine.

In 1978, Dr. Touchon relocated to Colorado to become director of intensive care at Mercy Medical Center in Durango, where he also later served as chief of medicine. Four years later, he moved to Huntington to accept his current posts as chief of cardiovascular medicine at the Marshall University School of Medicine and chief of cardiology at the VA Medical Center. In addition, since 1985 Dr. Touchon has been a professor of medicine and physiology at MU, and since 1988 has been director of cardiac rehabilitation at Cabell Huntington Hospital.

A fellow of the American College of Cardiology, Dr. Touchon is presently the governor of the West Virginia Chapter of this organization.

Dr. Hill was born in Parkersburg and received his M.D. degree from WVU in 1974. He did a two-year residency in general and thoracic surgery at Duke University Medical Center, and then became a research fellow with the NIH Academic Surgical Scholar Research Training Program at Duke for three years.

After his fellowship, Dr. Hill was the senior resident in general and thoracic surgery at Duke until 1983, when he was named chief resident. The next year, he joined the faculty as a teaching scholar in cardiac surgery and an instructor in surgery.

In 1985, Dr. Hill relocated to Morgantown to become an assistant professor of surgery at the WVU School of Medicine and a consultant at the VA Medical Center in Clarksburg. Two years later, Dr. Hill took on additional duties as an attending cardiothoracic surgeon at Monongalia General Hospital, and in 1990 he was promoted to associate professor of surgery at WVU.

In 1994, Dr. Hill was elected to *Best Doctors in America.* A noted author and researcher, Dr. Hill has published over 100 abstracts, chapters and articles, and has over 20 studies now in progress.

Third Mid-Winter session to focus on treatment of STDs

"Sexually Transmitted Diseases in Women and Adolescents" will be the title of this year's Third Scientific Session on Saturday, January 21 at 2 p.m. during the WVSMA/WVACP's 1995 Mid-Winter Seminars and Scientific Conferences at the Radisson Hotel in Huntington.

Topics for this session include *"Human Papilloma Virus Infections," "AIDS," "Update on Sexually Transmitted Diseases,"* and *"Herpes Virus and Other STDs."* Addressing these respective subjects will be **Thomas Rushton, M.D.**, an assistant professor of medicine at the Marshall University School of Medicine; **Robert B. Belshe, M.D.**, a professor of medicine and pediatrics at the St. Louis University School of Medicine; **Melanie A. Fisher, M.D.**, an associate professor of medicine at the WVU School of Medicine in Morgantown; and **Brant L. Viner, M.D.**, an assistant professor of medicine at the University of Massachusetts Medical Center.

Dr. Rushton is a Miami native who received his M.D. degree from the University of South Florida College of Medicine in Tampa in 1989. He did his internship and residency in internal medicine at Vanderbilt University Medical Center.

Dr. Ruston recently completed a two-year fellowship in infectious diseases and topical medicine at the University of South Florida College of Medicine before accepting his current post as an assistant professor of medicine at Marshall University. A diplomate of the American Board of Internal Medicine and the National Board of Medical Examiners, Dr. Rushton is a member of the Christian Medical and Dental Society and the American College of Physicians.

Dr. Belshe is a native of Hartford, Conn., who earned his medical degree from the University of Illinois College of Medicine, where he also completed his internship and residency. Following his residency, Dr. Belshe accepted a position in 1975 at the National Institutes of Health as a research associate in the National Institute of Arthritis and Infectious Diseases.

After three years at the NIH, Dr. Belshe joined the Department of Medicine at the Marshall University School of Medicine as an associate professor and chief of the Section of Infectious Diseases. He was promoted to professor of medicine in 1983 and also held the position of professor of microbiology. While on the faculty at Marshall, Dr. Belshe spent a year on sabbatical at the National Institute for Medical Research in London.

Belshe

Fisher

In 1989, Dr. Belshe assumed his current roles as a professor of medicine and pediatrics and director of the Division of Infectious Diseases at the St. Louis University School of Medicine. A fellow of the American College of Physicians, the Infectious Diseases Society of America, and the American Academy of Microbiology, Dr. Belse is a noted author who has written over 120 articles and chapters.

Dr. Fisher received her M.D. degree from the Milton S. Hershey Medical Center of Pennsylvania State University in 1977. She completed an internship and residency at WVU, and then joined the faculty for a year as an assistant professor of medicine in the Section of Comprehensive Medicine.

From 1982-84, Dr. Fisher was a clinical and research fellow in infectious diseases at the Hospital of the University of Pennsylvania in Philadelphia. After her fellowship, she returned to WVU to be an adjunct assistant professor of medicine in the Section of Infectious Diseases.

In 1989, Dr. Fisher was promoted to adjunct associate professor of medicine at WVU, and in 1991 she was promoted to her current position as associate professor of medicine. In addition, for over two years, she has been the interim chief of the Section of Infectious Diseases at WVU. Last year, Dr. Fisher was recognized for her outstanding teaching efforts by the WVU Department of Medicine.

Dr. Viner received an A.B. degree in romance languages and literatures from Amherst College in 1973, and the following year obtained an M.A. degree in Spanish and Portuguese from the University of Wisconsin. He continued his education in romance languages and literatures in 1974 at Harvard University, where he worked as a teaching fellow until 1979 when he was accepted at the Boston University School of Medicine, where he earned his M.D. degree in 1983.

Dr. Viner completed an internship and residency in internal medicine at Boston City Hospital. In 1986, he continued his postgraduate studies with a two-year fellowship in the Division of Infectious Diseases at the Boston University School of Medicine. After completing his fellowship, Dr. Viner joined the faculty at the University as an assistant professor of medicine, and this year he was promoted to his current role as an assistant profesor of medicine.

Medical Assurance president visits component societies

Derrill Crowe, M.D., president of the WVSMA's newly endorsed medical malpractice insurer Medical Assurance of West Virginia, Inc., recently visited several component societies to inform members about the company and the programs and services it offers.

In Dr. Crowe's presentations, he stressed Medical Assurance's financial stability and it's long-term commitment to WVSMA members. He reminded members that Medical Assurance has a proven track defense success record, recording defense successes in more than 93% of its cases. He also pointed out that Mutual Assurance maintains a "consent-to-settle" clause in its policy, something many other carriers do not offer to policyholders.

While visiting the component societies, Dr. Crowe also explained that Medical Assurance doesn't require that physicians make a surplus contribution prior to being insured. Since Medical Assurance is rated A+ (Superior) by A. M. Best, the company's financial strength means it doesn't require additional, non-deductible contributions from its policyholders. He also stated that the company is tenatively planning seven loss control seminars for 1995.

For more details about Medical Assurance, contact WVSMA Executive Director George Rider at (304) 925-0342.

WVHA Award Winner

At the WVSMA's recent Council Meeting, Dr. James Comerci, WSMA Council Chairman was presented the West Virginia Hospital Association's Distinguished Service Award by WVHA President Steven Summer in honor of his exceptional leadership in addressing West Virginia's health care issues.

Graeber to speak at Surgery Section meeting

Graeber

Geoffrey Graeber, M.D., professor of surgery in the Section of Cardiovascular and Thoracic Surgery at WVU, will be the speaker for this year's WVSMA Surgery Section breakfast meeting at 8 a.m. on Sunday, January 22 at 8 a.m. during the WVSMA/WVACP's 1995 Mid-Winter Seminars and Scientific Conferences.

Dr. Thomas Chang, chairman of the WVSMA's Surgery Section, is inviting all interested physicians and other health care professionals to attend Dr. Graeber's lecture on "*The Current Status of Video-Assisted Thoracic Surgery.*"

Dr. Graeber received his M.D. degree from the State University of New York in 1971, and then did a surgical internship and a residency in surgery at Johns Hopkins Hospital in Baltimore. From 1973-78, he continued his postgraduate studies at Upstate Medical Center in Syracuse, N.Y., with residencies in general and thoracic surgery.

Following his residencies, Dr. Graeber served from 1978-89 with the U.S. Army at the Walter Reed Army Medical Center in Washington, D.C., and obtained the rank of colonel. During most of this time, Dr. Graeber was also on the faculty of The Uniformed Services University of the Health Sciences in Bethesda, M.D.

In 1989, Dr. Graeber relocated to Morgantown to accept his current posts as a professor of surgery and director of surgical research at WVU. In addition to his academic responsibilities, Dr. Graeber is a staff thoracic surgeon at both Ruby Memorial Hospital and Monongalia General Hospital, and he serves as a consulting surgeon at Washington VA Medical Center in Washington, D.C., and at the National Cancer Institute in Bethesda, Md.

Dr. Graeber is a fellow of the American College of Chest Physicians and the American College of Surgeons. He is noted author who has published over 150 abstracts, articles and chapters.

To make reservations to attend this breakfast meeting, please contact Nancie Divvens at (304) 925-0342.

The Excitement is Snowballing...

Join us for the 1995 Mid-Winter Seminars and Scientific Conferences

January 19-22, 1995
Radisson Hotel - Huntington

The WVSMA's Mid-Winter Sessions will be held in conjunction with the Fourth Annual Scientific Meeting of the West Virginia Chapter of the American College of Physicians. Call the WVSMA at (304) 925-0342 for more information.

1995 Mid-Winter Registration Form

Name _____

Phone _____

Address _____

City _____ State ____ Zip Code_____

Payment by: ____ Check ____ Visa ____ MasterCard

Card Number _____

Expiration Date _____

Signature _____

If paying by check, please send registration form and check to:

West Virginia State Medical Association
P.O. Box 4106
Charleston, WV 25364
(304) 925-0342

Conference Cost:

WVSMA member	$125	_____
non-member	$175	_____
Lunch & Learn Physician	$50	_____
spouse/student	$35	_____
TOTAL		_____

Conomikes
9 a.m. - noon

Thursday, January 19
"Reception and Patient Flow Techniques"
(Lunch on your own)

1 - 4 p.m.

"Better Collections, Billing and Insurance Methods"

morning only	$95	_____
afternoon only	$95	_____
both sessions	$185	_____
TOTAL		_____

Continuing Medical Education

Listed on this page are some of the upcoming CME programs which will be held in the state. Unless otherwise noted, the events are presented at the location under which they appear.

If you would like to have the CME programs offered by your institution or association for physicians printed in the *Journal* or obtain more details about the meetings listed, please contact Nancy Hill, managing editor, at 925-0342.

Cabell County Medical Society - Huntington

January 12
"Recognizing and Treating Depression," Jeff Kelsey, M.D., Gateway Holiday Inn, 6:30 p.m.

Robert C. Byrd Health Sciences Center of WVU - Charleston

January 19
(Teleconference) "Cardiovascular Intervention," Mark C. Bates, M.D.

February 2
(Teleconference) "Opportunistic Infections in HIV Disease," Elizabeth A. Funk, M.D.

February 16
(Teleconference) "Obstetrical Ultrasound: Tips and Techniques," David A. Chaffin, M.D.

Robert C. Byrd Health Sciences Center of WVU - Morgantown

January 27-29
"2nd Annual Critical Care to Rehabilitation Conference: A Pulmonary Focus" (sponsored by the WVU School of Medicine, Dept. of Medicine, and MountainView Regional Rehabilitation Hospital), Snowshoe

January 27-29
"Advanced Life Support for Obstetrics" (sponsored by the WVU Dept. of Family Medicine and Preston Memorial Hospital), Morgantown

January 27
"The Ethics and Law in West Virginia of Health Care Decision Making for Incapacitated Patients" (sponsored by the WVU Center for Health Ethics and Law), Flatwoods

West Virginia State Medical Association - Charleston

January 19-22
WVSMA/WVACP's Mid-Winter Seminars and Scientific Conferences, Radisson Hotel, Huntington

Outreach Programs

Key to Sponsors

★ *Robert C. Byrd Health Sciences Center of WVU, Morgantown*

☐ *CAMC/Robert C. Byrd Health Sciences Center of WVU, Charleston*

Elkins ★ Davis Memorial Hospital (held at Elkins Motor Lodge), 6:30 p.m., "Antibiotics Utilization," Wes Farr, M.D.

Fairmont ★ Fairmont Clinic, Jan. 18, 1 p.m., "Non-Melatonic Skin Cancers," Rodney Kovach, M.D.

★ Fairmont Clinic, Feb. 15, 1 p.m., "Juvenile Diabetes," Evan Jones, M.D.

Man ☐ Man Appalachian Regional Hospital, Jan. 18, 6:30 p.m., "Treatment of Osteoporosis," Alfred K. Pfister, M.D.

Martinsburg ★ VA Medical Center, 3 p.m., "Mechanical Ventilation," Marvin Balaan, M.D.

Montgomery ☐ Montgomery General Hospital, Jan.. 4, 12:30 p.m., "Recent Advances in Anti-Infective Therapy," Christine Teague, Pharm.D.

Oak Hill ☐ Plateau Medical Center, Jan. 24, 6:30 p.m., "Treatment of Osteoporosis," Alfred K. Pfister, M.D.

Parkersburg ★ Camden-Clark Memorial Hospital, Jan. 18, 7:30 a.m., "Hirsutism," Stephen Grubb, M.D.

★ Camden-Clark Memorial Hospital, Feb. 8, 7:30 a.m., "Antibiotic Allergies in Children," Nevin Wilson, M.D.

★ Camden-Clark Memorial Hospital, Feb. 22, 7:30 a.m., "Applying Basic Immunology to Clinical Practice," Paris T. Mansmann, M.D.

Philippi ★ Broaddus Hospital, Jan. 5, 7 p.m., "Skin Problems in Long-Term Care," William Welton, M.D.

★ Broaddus Hospital, Feb. 2, 7 p.m., "Seizure Management," Raj Sheth, M.D.

Point Pleasant ☐ Pleasant Valley Hospital, Jan. 26, noon, "TMJ," Kent Jackfert, D.D.S.

Richwood ☐ Richwood Area Medical Center, Jan. 12, 5:15 p.m., "Cancer Prevention Screening," Arvind Kamthan, M.D.

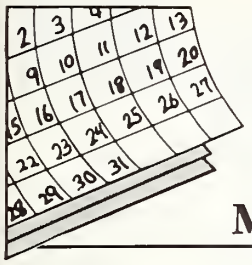
Ripley ☐ Jackson General Hospital, Jan. 13, 12:15 p.m., "Suicide Assessment and Prevention," Tom Ellis, Ph.D.

Spencer ☐ Roane General Hospital, Jan. 17, 12:15 p.m., "Pharmacotherapy in ACLS," Anita Lorenzo, Pharm.D.

Waynesburg, Pa. ★ Greene County Memorial Hospital, 7 p.m., "Assessment of Abdominal Injuries," Laurel Omert, M.D.

White Sulphur Springs ★ The Greenbrier Clinic, Feb. 27, 4 p.m., "The Red Eye," Mark Mayle, M.D.

Williamson ☐ Williamson Appalachian Regional Hospital, Jan. 26, 6:30 p.m., "Alcohol Withdrawal Syndromes," James Griffith, M.D.



Medical Meetings

January

10-14–20th Annual Meeting of the Alliance for Continuing Medical Education (sponsored by George Washington University) Phoenix, Ariz.

15-21–Southern Clinical Neurological Society, Marathon, Fla.

18-21–American Group Practice Association, New Orleans

19-21–Incorporating Contemporary Genetics into Your Practice (sponsored by The South Florida Chapter of the March of Dimes), Palm Beach, Fla.

19-22–WVSMA/WVACP 1995 Mid-Winter Seminars and Scientific Conferences, Huntington

20-21–Clinical Innovations in OB/GYN Ultrasound (sponsored by Meetings & Management Techniques Plus), San Antonio, Texas

20-22–National Association of EMS Physicians, Naples, Fla.

27–The Ethics and Law in West Virginia of Health Care Decision Making for Incapacitated Patients (sponsored by the West Virginia Network of Ethics Committees), Flatwoods, W.Va.

February

5-8–Southern Surgical Congress, New Orleans

6-8–Cardiovascular Conference at Snowshoe (sponsored by the American College of Cardiology), Snowshoe, W.Va.

9-12–50th Annual Postgraduate Ob/Gyn Assembly (sponsored by the Ob/Gyn Assembly of Southern California), Beverly Hills, Calif.

11-18–Super EMG XVI (sponsored by Ohio State University), Kohala Coast, Hawaii

16-19–American Academy of Pain Medicine, Palm Springs, Calif.

16-21–American Academy of Orthopaedic Surgeons, Orlando, Fla.

20-22–Cardiopulmonary Rehabilitation Symposium: Status '95 (sponsored by the University of Florida), Orlando, Fla.

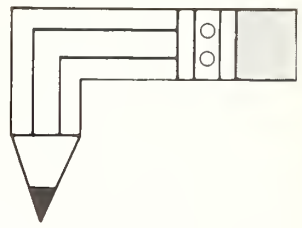
22-25–The 2nd International Conference on Advances in the Biology and Clinical Management of Melanoma (sponsored by the University of Texas M.D. Anderson Cancer Center), Houston

February 24-March 1–American Academy of Allergy and Immunology, New York City

February 27–March 2–The Alton D. Brashear Postgraduate Course in Head and Neck Anatomy (sponsored by Virginia Commonwealth University), Richmond

For More Information . . .

Contact the Journal at (304) 925-0342.



Poetry Corner

Christmas Prayer

Candlesticks and Christmas lights
Slavic war and ghastly sights.

Santa Claus and gifts galore
Broken limbs and bloody gore.

Why, Oh God, are such as these?
Teach us, Lord, and help us please.

Give us peace and wake our love.
May these come from Him above.

Stephen D. Ward, M.D.

Please address your submissions for Poetry Corner to Stephen D. Ward, M.D., Editor, West Virginia Medical Journal, P. O. Box 4106, Charleston, WV 25364.

This page of material is submitted and paid for by the Bureau for Public Health.

Report shows impact of diabetes among West Virginians

According to a new report by the Bureau of Public Health, "*The Burden of Diabetes in West Virginia,*" our state leads the nation in the death rate from diabetes, and health officials estimate that 25% of all West Virginians age 65 and older are affected by the disease.

The report reveals that diabetes is the leading cause of adult blindness, kidney failure, and non-traumatic leg and foot amputations, as well as the 7th leading cause of death and the number one medical risk factor for birth defects. Blacks and women are most likely to be affected by diabetes, and it occurs more frequently among people with low education and income levels.

From 1988 and 1992, hospitalization rates in the state for diabetics were higher than national rates, and nearly one of every eight dollars billed by hospitals for inpatient services was for diabetes-related complications.

Recent research indicates intensive disease management can better control diabetes and greatly reduce the risk of deadly complications. To accomplish this, individuals with diabetes must understand disease self-management. Unfortunately, access to professionals who can provide primary care and appropriate supervision is limited, and there is a shortage of professionals with specialties important to the prevention and control of diabetes complications. Currently, there are 55 certified diabetes educators in West Virginia, but most are located in urban hospital and academic settings.

The Bureau's Diabetes Control Program, in consultation with the West Virginia Diabetes Advisory Committee, is developing strategies to reduce the impact of diabetes in West Virginia. For more information, contact Helen Rentch, West Virginia Diabetes Control Program Manager, at (304) 558-0644.

Contributions to rural health care recognized

The second annual Governor's Rural Health Awards were recently presented at the West Virginia Rural Health Conference in Morgantown. This year's recipients were Shirley C. Neel, of Monroe Health Center, for Outstanding Rural Health Achievement; Tom Harward, a physician assistant from Barbour County, for Outstanding Rural Health Practitioner; and Mercer Health Right, Inc., for Outstanding Rural Health Program.

Neel has served as administrator of Monroe Health Center since 1974, during which time the center has become a model for integrating public health services in a primary care center in an isolated rural area. She has helped develop innovative programs concerning farm safety, highway accident prevention, hunter safety, and breast and cervical cancer screenings. In addition, Neel has organized a committee to address local health issues and developed a consortium of providers in Monroe, Greenbrier and Summers Counties to create rural training sites for students in health professions.

Harward has served Barbour County as a physician assistant for 16 years. He carries a patient load of more than 6,000 encounters a year, yet continues to make regular house calls to the elderly. Harward helped establish an independent community health center in Belington eight years ago, and assumed a dual role as clinic administrator and medical provider during the difficult start-up period. In addition, he was also instrumental in establishing the state's first full-time, high school-based wellness center through Belington Clinic, and is working with school nurses and the local health department to develop mini-clinics at all elementary and middle schools in the county.

Mercer Health Right, Inc. has been serving the community since 1990. This public/private partnership delivers free health care services for medically underserved and uninsured indigent residents of Mercer and McDowell Counties and neighboring Tazewell County, Va. Services are offered 21 hours a week by a staff that includes paid and volunteer professionals and volunteer laymen. Volunteer staff provide over 68% of the hours worked, and community participation provides over half of the clinic's needs in the form of in-kind services, donated equipment and supplies, and professional services.

Grant to help boost state's 911 coverage

The Bureau of Public Health has received a grant for a model project called the *"West Virginia Emergency 911 Initiative - Empowering Local Area 911 Implementation,"* to help county governments develop plans for Emergency 911 systems. The $46,250 one-year grant was awarded by the U.S. Department of Health and Human Services' Bureau of Human Resources Development.

Currently, about half of the state's population is served by some type of 911 system. However, most of those systems are concentrated in urban rather than rural areas, and 28 counties have no 911 coverage. The goal of this project would be to develop the steps that could be used in any county to determine if, when, where and how a 911 system would be implemented.

The plan, which will be piloted in Taylor County throughout next year, will consist of several components involving cooperative efforts of county government and emergency personnel. The first step will be to determine if there is a need for a 911 system in the county and if the need outweighs the cost. Location, staffing, equipment and funding logistics would then be worked out. A public awareness campaign would also be developed to gain support for the new system.

County commissions in each county would have the final say on whether or not a 911 system would be installed. Once county officials would make this decision, the plan will have laid the groundwork for them to proceed.

For more details, contact Jim Doria of the Office of Emergency Medical Services at (304) 558-3956.

IN MEDICAL SYSTEMS

-14 years experience
-Based in West Virginia
-We support over 450 physicians
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Compiled from material furnished by the Robert C. Byrd Health Sciences Center of West Virginia University, Communications Division, Morgantown

Profs share award for safer genetic therapy

Two assistant professors in the School of Medicine, Vinay K. Pathak, Ph.D., and Wei-Shau Hu, Ph.D., have accepted a $3,000 award for creating a safer method of delivering genetic therapy. Their research is the basis of a pending patent application which they have entitled *"E-minus Vectors: Safer Retroviral Vectors for Gene Therapy."*

Gene therapy uses viruses to carry the new genes into the cells of the patient. The gene is targeted at certain types of cells in the patient's body - - but some researchers fear that an introduced gene could spread to other types of cells, leading to unpredictable side effects.

The development by Drs. Pathak and Hu is a virus that can insert itself into the target cells, and at the same time destroy its own capacity to replicate in the body. This prevents the spread of the introduced gene to non-target cells so it "has important potential in gene therapy, particularly in cancer," according to Dr. Pathak.

The $3,000 award, which was split equally between the two researchers, was provided by Research Corporation Technologies. The new retroviral technique developed at the Cancer Center is the first WVU patent chosen by the Research Corporation in nearly two decades.

Two WVU students share credit for the work: John Julias of Lewisburg, a graduate student in biochemistry; and David Hash of Beckley, who worked in Dr. Pathak's lab as an undergraduate.

Smith presents abstract

Dr. Lee Smith, assistant professor of emergency medicine, presented his abstract *"Utilization of Physician Assistants as Mid-level Providers in Emergency Medicine"* last month at the 88th Annual Scientific Assembly of the Southern Medical Association.

Sheth presents study at epilepsy meeting

Sheth

Dr. Raj Sheth, assistant professor of neurology and pediatrics, delivered the results of his study on the effects of anti-seizure medications at the annual meeting of the American Epilepsy Society.

This study, which looked at the effects that the two most frequently prescribed anti-seizure medications have on bone calcium, was conducted by Dr. Sheth with colleagues at the Janeway Child Health Center at Memorial University of Newfoundland.

Bosnian Civil War victim treated at WVU

Sakib Dzananovic, a 28-year-old Muslim from Bosnia, is being cared for by doctors and physical therapists at WVU after suffering injuries to his lower leg leg in a shell blast in August 1992.

Dzananovic arrived in West Virginia last month as a result of the efforts of the Bosnian Injury Relief Fund and the International Organization for Migration. He was examined by Dr. David Blaha, chair of the Department of Orthopedics, and is undergoing physical therapy at WVU Hospital's outpatient physical therapy facility.

Post lectures in Brazil

Dr. William Post, assistant professor and chief of the Section of Sports Medicine and Shoulder Surgery in the Department of Orthopedics, was a guest professor at the recent Brazilian National Orthopedic Congress in Salvador, Brazil.

At the meeting, Dr. Post presented nine lectures, including discussions on recent advances in the diagnosis and treatment of knee and shoulder problems, patellofemoral problems, and rotator cuff problems.

VA Medical Center joins MDTV network

Mountaineer Doctor Television (MDTV) expanded its network this month to include the Louis A. Johnson Memorial Veterans Administration Medical Center in Clarksburg.

This two-way, interactive television system allows physicians at the Clarksburg hospital to consult with colleagues at WVU and present patients to WVU specialists. It also enables staff at the VA Hospital to participate in medical grand rounds and other WVU educational events.

Grant to fund minority apprenticeship project

The HSC's Office of Research and Graduate Studies will again hold its Minority Research Apprenticeship Program this summer thanks to a $32,747 grant from the NIH.

This program encourages minority high school students to pursue careers in biomedical research and health professions, and also provides training for high school teachers.

George Hedge, Ph.D., associate dean of research and graduate studies, is director of the program. Christine Baylis, Ph.D., of the Department of Physiology, is chair of the oversight committee, and Valerie Lemasters, assistant director of research programs, is the program manager.

Faculty participate in EMS course at Canaan

Four faculty from the Department of Emergency Medicine and the administrator for the Center for Rural Emergency Medicine (CREM) recently participated in the West Virginia EMS Medical Directors Course held at Canaan Valley Resort.

Those lecturing were Dr. Debra Paulson, assistant professor; Dr. Lee Smith, assistant professor; Dr. John Prescott, associate professor and chair; Dr. Janet Williams, assistant professor; and Leah Heimbach, CREM administrator.

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West Virginia is ranked third in the nation for smoking and first in the nation for smokeless tobacco use. The West Virginia Tobacco Control Coalition supports three statewide policy measures to reduce tobacco use and its effects. Help improve the health of West Virginians by advocating for these pieces of legislation:

Statewide Clean Indoor Air would restrict smoking in designated public places and work sites. Protects nonsmoking citizens and provides a supportive environment for those who want to quit.

Youth Access Prevention would require retailers to be licensed to sell tobacco products to hold them more accountable to current law that prohibits sales to people under 18. Prohibits free sampling or coupon distribution and requires lock-out devices for vending machines.

Tobacco Excise Tax would increase the excise tax on cigarettes and impose the first tax on smokeless tobacco. Studies show that as the price increases, smoking rates decline - especially among youth.

WEST VIRGINIA TOBACCO CONTROL COALITION

The West Virginia Tobacco Control Coalition is made up of 50 member organizations, including the American Lung Association of West Virginia, the American Cancer Society, West Virginia Division, Inc. and the American Heart Association of West Virginia.

Marshall University School of Medicine

Compiled from material furnished by the Office of University Relations, Marshall University, Huntington

Med student training to include clerkship with Hospice

Hospital rotations generally don't give medical students an intimate look at how families deal with terminal illnesses and deaths.

Dr. Daniel Cowell, chairman of the psychiatry department at Marshall University, recognized this and wondered if Hospice of Huntington, an organization that cares for people with terminal illnesses and provides support for their families, would take on third-year medical students for clerkships as part of their psychiatry training.

The suggestion was heartily accepted by Hospice, Cowell said. The first three Marshall medical students to work with Hospice recently finished their eight-week rotation, and a new group began this week.

"I think people would really like to know that medical students are getting exposure to end-of-life issues," he said. "One of the complaints you often hear about in medicine is that doctors are too rushed, too impersonal."

Since 1982, Hospice of Huntington has taken care of 2,000 patients and their families, said Charlene Farrell, executive director of Hospice.

The number of patients cared for through Hospice has grown exponentially over the years, with the organization now caring for 70 to 90 patients on any given day. Each patient is put with a team that takes care of a certain geographic area. There are four Hospice teams that cover Cabell, Wayne and Lincoln counties in West Virginia and Lawrence County in Ohio.

It is apparent already that the medical students are doing more than observing the Hospice program, Farrell said. They're contributing to the patients' care.

Jackie Workman, an oncology registered nurse, was working with Marshall medical student Todd Lares on a visit when one of her patients died.

"When we got there to the house, the patient had just died," she said. "He went in with me, and he was just excellent. He was very comforting with the family.

"It was a really good experience," she said. "He was a lot of help to me at that particular time."

That experience, says Lares, was of great value to his medical education.

"Being involved in that situation, it made me realize that my medical education had come short," he said. "A formal medical education does not teach you how to deal with death.

"When the battle is lost, you still have a person lying there with physical, emotional, social and spiritual needs. And we're not taught to deal with that."

Lares, who had experienced the other side of Hospice care when his wife's grandmother died, said he will be a better doctor for his involvement.

"I wouldn't trade it for anything," he said.

Cowell said the importance of linking students with Hospice is teaching them the difference between pain and suffering and disease and illness.

"I believe that we in the department of psychiatry have a special responsibility to sensitize students to the humanistic aspects of medical practice -- the psychosocial aspects -- in a way that they cannot get with any other service," he said.

Binni Bieler, associate professor of psychiatry, accompanied the medical students to an orientation session at Hospice last week.

As the Hospice workers -- a nurse, a social worker and a counselor -- explained their roles, Bieler pointed out to the students their main task: "To come with respect. I think that's the bottom line that we ask for," she told the students.

"I think this is the least busy work thing you're going to do," she said.

During the Hospice clerkship, the students will learn to watch patients for signs of grief and depression, such as weight gain or loss, exhaustion, anxiety or shortness of breath.

"They may laugh at you when you walk in the door," Lisa Kaplan, a Hospice counselor, told the students. "But it's normal. They're grieving."

Taofik Sadat, one of the medical students, said even pediatricians have to face death with their patients.

"I think what I'm expected to learn is how to deal with the dying patient. I think it will be very beneficial to me."

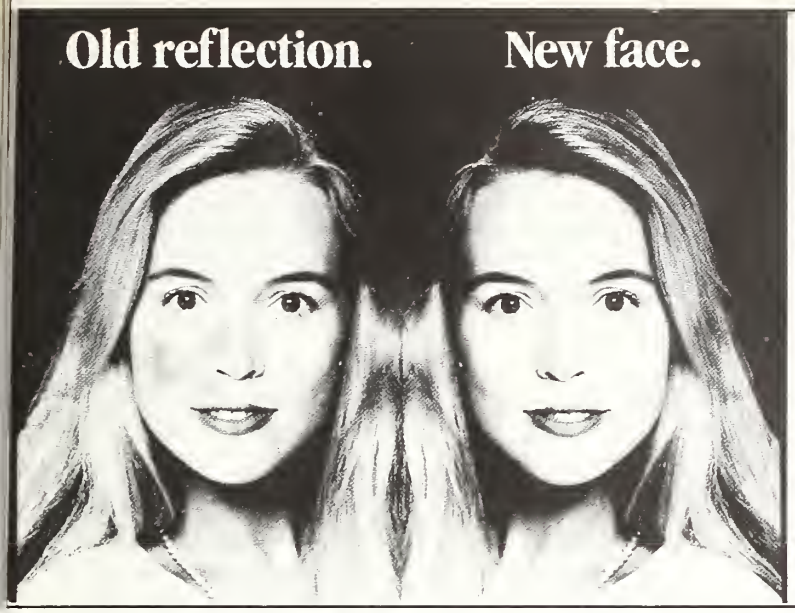
Farrell said she viewed the idea as an opportunity to help educate the next generation of physicians.

"They get to see the patient in their home environment, which is a little different than seeing them in the sterile environment of a hospital," she said.

Bieler described the partnership as an example of the new, community-based approach to health care.

"This is a perfectly good example of where health care

(Reprinted with permission from the Herald-Dispatch, Huntington)



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Obituaries

Paul L. McCuskey, M.D.

Dr. Paul L. McCuskey, 81, of Parkersburg, died July 10 in Camden-Clark Memorial Hospital following an extended illness.

Dr. McCuskey was born in Shinnston, a son of the late Rev. Roy McCuskey and Jessie Fulton McCuskey. He was a 1931 graduate of Wheeling High School, a 1935 graduate of West Virginia Wesleyan College and a 1939 graduate of Northwestern Medical School.

After interning at the Jersey Medical Center, Dr. McCuskey did postgraduate work at the University of Pennsylvania from 1941-42. He was assigned to the Army Medical Corps' 106th Station Hospital in Napoli, Italy, in 1943, and was honorably discharged at the end of World War II. He received training in urology and opened his own practice in Parkersburg in 1947, where he retired in 1978.

A fellow of the American College of Surgeons and a diplomate of the American Board of Urology, Dr. McCuskey was on the staffs at St. Joseph's Hospital and Camden-Clark Memorial Hospital, and also on the consulting staff at Marietta Memorial Hospital.

Dr. McCuskey served on the board of trustees at West Virginia Wesleyan College, where he was awarded the Alumni of the Year Award in 1965 and received a Doctor of Human Letters in 1969. Dr. McCuskey also served on the board of the American Red Cross and held a six-year term on the Wood County Board of Education.

In addition to being a member of the WVSMA, Dr. McCuskey was a member of Kappa Alpha fraternity, Alpha Kappa Kappa medical fraternity, the Parkersburg Academy of Medicine, the AMA, the American Urological Association, the Mount Olivet Masonic Lodge, the 32nd degree Scottish Rite Bodies, Nemesis Shrine, BPOE 198, the Parkersburg Kiwanis Club and the American Legion. He was a member and past director of the Royal Order of Jesters 156.

Survivors include his wife, Martha Foster McCuskey; one son, David McCuskey, Las Vegas; three daughters, Martha Hartley, Camp Hill, Pa., Maggie McCuskey, Athens, and Jennie McCuskey, Las Vegas; four grandchildren; two great-grandchildren; and one sister, Lea Whitley, Ojai, Calif. He was also preceded in death by an infant son, and one brother, Dr. John McCuskey.

Paul Delaine Snedegar, M.D.

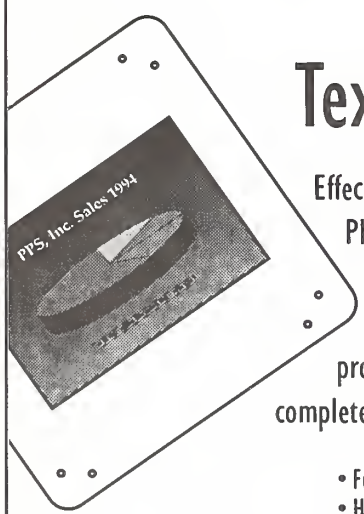
Dr. Paul Delaine Snedegar, 80, died at his home in Elkins on October 1.

Dr. Snedegar was born in Elkins, a son of the late W.N. and Nellie Bly Beard Snedegar. He received an A.B. degree from Davis and Elkins College in 1936 and then attended the University of Michigan. Dr. Snedegar earned his M.D. degree from Duke University Medical School in 1941, and did his internship at Union Memorial Hospital in Baltimore, Md., and his residency at the University of Virginia.

In 1945, Dr. Snedegar opened his practice in Elkins and he was a Davis and Elkins College physician for 25 years. Throughout his career, Dr. Snedegar was affiliated with Davis Memorial Hospital in Elkins.

A diplomat of the American College of Otolaryngology, Dr. Snedegar had been a member of the WVSMA since 1946. He was also a member of the Davidson Club at Duke University and the West Virginia Beekeepers Association.

Dr. Snedegar is survived by his wife, Martha Bogue Snedegar. Also surviving are two sons, Maxwell B. Snedegar, Ardmore, Okla., and Marshall K. Snedegar, Charleston; one daughter, Jan S. Nash, Norristown, Pa.; and five grandchildren, Todd, Kara, Ryan, Ervin and Sean Paul. He was preceded in death by one brother, Nunley Snedegar, and one sister, Margaret Gray Bauld.



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The West Virginia State Medical Association
Medical Student Section

Annual Meeting
January 21, 1994
The Radisson Hotel, Huntington, West Virginia

Program

8:00 - 8:30 am	Registration - Kentucky Room
8:30 - 9:00 am	Welcome - WVSMA Representatives
9:00 - 10:00 am	**Special Session - "Rural Healthcare in WV"** Donald Weston, MD, Vice Chancellor for Health Sciences, Charleston, WV
10:00 - 11:00 am	**Legislative Update!** - Stephen E. Haid, Ph.D., The Perry and Haid Group, Charleston, WV
11:00 - 11:30 am	Break - Visit Exhibits
11:30 - 12:30 am	**Lunch and Learn** - Susan Griffith, Physician Recruiter, Jackson General Hospital, Luncheon Sponsored by Marshall University School of Medicine
1:00 - 4:00 pm	Business Meeting Presidential Address Component Society Reports Election nominations Committee Reports

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